



Interdisciplinary Procedure Manual for Health Workers of Liberia

Instructor/Assessor's Version



USAID
FROM THE AMERICAN PEOPLE



REBUILDING BASIC HEALTH SERVICES
IN LIBERIA PROJECT

Introduction

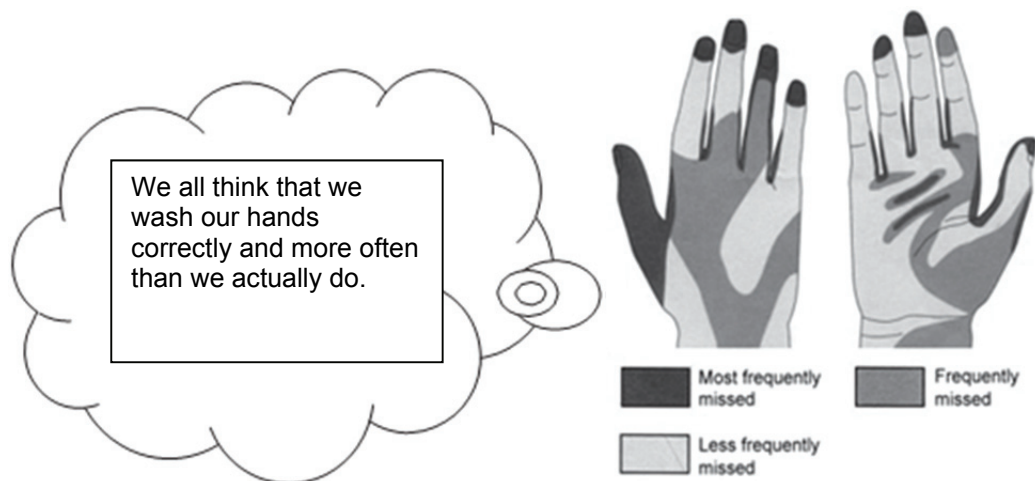
Welcome to the Liberia Interdisciplinary Procedure Manual (IPM) for RNs, RMs and PAs. The checklists, protocols, and job aids in this manual are integrated to assist you in practicing and preparing for becoming a competent health care provider.

Please note that the tasks in **red** are required of all RN, RM, and PA providers (cross-cutting). Other **black** tasks may be required of only one or two cadres. Tasks that are required by all + EHT will be denoted in **green**. An interdisciplinary team of assessors would be able to sign you off on the cross-cutting tasks, reducing time and increasing the capacity of assessment. **The bolded tasks are those that you should be prepared to be assessed on as they have been determined through the Task Analysis Study as critical tasks to your repository of competencies as a health provider in Liberia.**

When assessed, you may not be given an entire service task, but rather a critical component of the task, as each station would not require more than 10 minutes to accommodate all learners in an efficient manner.

Only **validated assessments** in this IPM should be used for valid and reliable assessment of Learners. As they are validated and more resources become available or further competencies are identified, more assessments may be added to this IPM. Likewise, assessments could be deleted.

The single, most important step in preventing disease and reducing risk of becoming sicker once infected is hand hygiene. Hand hygiene may be handwashing or use of alcohol-based hand rub. However, if hands are visibly soiled, handwashing is recommended. Because we and others are not able to see these virulent pathogens, humans often minimize handwashing, but in every procedure included in the manual it is a critical step. It is included in this manual also as a separate task to be assessed and passed. Of note are the fingertips (*under fingernails*), thumbs and the left hand ring finger (probably with ring/s on).



Acknowledgments

This manual was made possible by the USAID Rebuilding Basic Health Services in Liberia project (RBHS) and the support of the Ministry of Health and Social Welfare (MOHSW). Jhpiego Global Learning Office Senior Technical Advisor A. Udaya Thomas and Education and Training Advisor Marion Subah were instrumental in leading the validation process for this manual and creating this manual. They are both Jhpiego-Certified International Training Experts. Udaya Thomas was the Principal Investigator for the Task Analysis that informed the content of this IPM and Lead Trainer for the Validation Process. Marion Subah was the Field and Co-Investigator of the Task Analysis study and Co-trainer and Facilitator for sustaining the Validation Process as the IPM evolves in Liberia. Training Assistant Nowai Johnson was also instrumental in assisting with the process and setting up the workshops for the working group.

Special thanks go to Liberian typist Marian N’Jie Lloyd and for final editing and formatting completed by Jhpiego’s publications unit.

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LIST OF VALIDATED CHECKLISTS

Use for Summative Assessment

Validated Checklist	Minimum Passing Score
Checklist 1: Admission	100%
Checklist 2: Admission of a Woman in Labor	75%
3: Antenatal Care—Focused Antenatal Care Guide	78%
Checklist 4: Antenatal History Taking	74%
Checklist 6: Bimanual Compression	76%
Checklist 9: Supporting Successful Breastfeeding	79%
Checklist 10: Cardiopulmonary Resuscitation	100%
Checklist 11.1: Catheterization (Female)	84%
Checklist 11.1: Catheterization (Female)	79%
Checklist 14.1: Monitoring Labor Progress Using the Partograph	75%
Checklist 14.2: Normal Delivery and Active Management of Third Stage of Labor	86%
Checklist 14.5: The Management of Woman in Labor With Baby in Occiput Posterior Position	85%
Checklist 15: Enema Administration	78%
Checklist 16: Episiotomy Repair	68%
Checklist 17: Family Planning Counseling (Balance Counseling Strategy using MEC Wheel)	76%
Checklist 17.6: Jadelle® Insertion and Removal	87%
Checklist 17.8: IUD Insertion and Removal	67%
Checklist 18: Nasogastric (NG) Tube Gavage Checklist 18.1: Nasogastric (NG) Tube Gavage (For Babies and Children)	76%
Checklist 20.2: Hand Hygiene	100%
21.1: Management of the Sick Young Infant From Birth Up to 2 Months	72%
21.2: Management of the Sick Child Age 2 Months Up to 5 Years	78%
Checklist 23: Kangaroo Mother Care	100%
Checklist 25: Malaria Rapid Diagnostic Test	87%
Checklist 26: Management of Prolapsed Cord	83%
Checklist 27: Management of Shock	74%
Checklist 29: Manual Removal of the Placenta	78%
Checklist 30: Manual Vacuum Aspiration	76%

Validated Checklist	Minimum Passing Score
Checklist 32: Measuring Upper Arm Circumference (MUAC)	94%
Checklist 33.1: Administering an Intramuscular Injection	87%
Checklist 33.1: Administering an Intramuscular Injection Checklist 33.1: Administering an Intramuscular Injection	78%
Checklist 33.4: Establishing Two IV Lines	78%
Checklist 33.5: Administering Nasal Installation	79%
Checklist 33.6: Ophthalmic Medication Administration	89%
Checklist 33.7: Administering Oral Medications	100%
Checklist 33.8: Otic Medication Administration	70%
Checklist 33.9: Rectal Medication Administration	100%
Checklist 33.10: Respiratory Medication Administration	83%
Checklist 33.11: Transdermal Medication Administration	73%
Checklist 35: Nasogastric Tube Insertion	80%
Checklist 35: Nasogastric Tube Insertion	72%
Checklist 36.2: Bathing an Infant	98%
Checklist 36.2: Bathing an Infant	81%
Checklist 36.3.1: Measuring Infant Body Temperature	95%
Checklist 36.4: Newborn Resuscitation	80%
37: Supplement: The “Simple Solution”—Homemade Oral Rehydration Salts (ORS) Recipe Checklist 38: Preparation and Administration of Oral Rehydration Salts (ORS)	86%
Checklist 39: Oxygen Administration	77%
Checklist 40: Physical Examination	92%
Checklist 40.2: Taking Axillary Temperature with Mercury Thermometer	100%
Checklist 40.3: Measuring Blood Pressure	100%
Checklist 40.4: Taking a Radial Pulse	100%
Checklist 40.5: Taking an Apical Pulse	100%
Checklist 40.6: Taking Respirations	92%
40.7: History and Physical	76%
40.9: Hearing Check	91%
Checklist 40.10: Oral Examination/Examination of the Pharynx	70%
Checklist 40.11.1: Swallow Test	67%
Checklist 40.12: Respiratory Examination	75%

Validated Checklist	Minimum Passing Score
Checklist 40.14: Breast Examination	66%
Checklist 40.15: Abdominal Examination	80%
Checklist 40.16: Iliopsoas Sign	80%
Checklist 41.1: Pre-Discharge Postpartum Interview and Physical Examination	76%
Checklist 41.3: Postnatal Discharge Instructions—Newborn Danger Signs	82%
Checklist 42: Setting Up a Sterile Field	82%
Checklist 42.1: Putting On and Removing Sterile Gloves	100%
Checklist 43: Sputum Specimen Collection	80%
Checklist 46: Suture Removal	67%
Checklist 48: Venipuncture Blood Collection	79%
Checklist 49.2: Dressing a Simple Wound	82%
Checklist 49.3: Incision and Drainage	68%
Checklist 49.4: Irrigating Wounds	85%
Checklist 49.5: Sterile Dressing Change	77%

CHECKLIST 1: ADMISSION

(To be completed by the **Assessor**)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR ADMISSION	
STEP	SCORE
GETTING READY	
1. Greet the patient and any relatives respectfully.	
2. Explain to the patient clearly the purpose for the admission, and answer any questions.	
3. Orient the patient to the hospital environment.	
4. Check the patient's temperature, pulse, respiration, and blood pressure; order patient lab test if applicable.	
5. Ask the patient's relatives to wait outside the door unless they will assist the client.	
6. Provide privacy.	
PROCEDURE	
7. Help the patient undress if necessary to put on the hospital gown, and help put the patient in bed comfortably.	
8. Review the patient information and pick up all orders.	
9. Perform hand hygiene.	
10. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO CONDUCT ADMISSIONS

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (*in case of need to remediate or other*):

CHECKLIST 2: ADMISSION OF A WOMAN IN LABOR

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

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Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR ADMISSION OF A WOMAN IN LABOR	
STEP	SCORE
GETTING READY	
1. Greet the woman and family respectfully.	
2. Provide privacy and make the woman feel comfortable.	
3. Gather necessary materials.	
PROCEDURE	
4. Explain to the woman that you will ask questions.	
5. Listen carefully to answers.	
6. Review antenatal record or ask total antenatal visits, problems.	
7. Record admission information: name, age, time of arrival, address, hospital number.	
8. Labor pains: when they began, how often, where are they felt?	
9. Ask about fetal movement.	
10. Ask about weeks of pregnancy, LNMP.	
11. Is the bag of waters broken? When? What is the color?	
12. Ask about mucus/bloody show or bleeding.	
13. Ask about signs of pre-eclampsia: headache, epigastric pain, severe heartburn.	
14. Ask about intake and output: last time to eat and drink, last stool and urine.	
15. Ask whether she has taken any medicine or treatment to increase or decrease pain, any allergies.	
16. Ask if birth attendant of family came along.	
17. Ask If HIV counseling and testing was done.	
PHYSICAL EXAMINATION	
18. Ask the woman to empty her bladder.	
19. Explain to her what you are going to do.	
20. Help the woman get comfortable.	
21. Perform hand hygiene.	
22. Check blood pressure, temperature, and pulse.	
23. Look at her general condition: height (too short), hydrated, worried, malnourished?	
24. Check conjunctiva for pallor (sign of anemia).	

CHECKLIST FOR ADMISSION OF A WOMAN IN LABOR	
STEP	SCORE
25. Ask the woman to lie down with pillow or cloth under head and shoulders.	
26. Do abdominal examination: uncover abdomen.	
27. Look at uterus for unusual shape, size, or scar.	
28. Check for contractions and fetus movements.	
29. Palpate uterus for fetus lie, presentation, and position.	
30. Palpate for descent.	
31. Auscultate and count fetal heart rate (FHR) for 1 minute.	
32. Feel uterus for contractions frequency, duration, and strength.	
33. Cover the abdomen.	
VAGINAL EXAMINATION	
34. Provide privacy.	
35. With the woman on her back, ask her to bend her knees more and to spread her legs apart.	
36. Perform hand hygiene, put on gloves.	
37. Clean the genital area with antiseptic solution/soap and water.	
38. Put antiseptic lubricant onto gloved examining fingers.	
39. With other gloved hand, separate the woman's labia.	
40. Look at vaginal opening for discharge, blood, amniotic fluid, meconium, sores, or warts.	
41. Gently insert 2 fingers of examining hand into vagina.	
42. Do not remove fingers until the vagina examination is done.	
43. Feel the vagina: moist, dry, hot, or scarring.	
44. Feel the cervix: effacement, dilatation, or if umbilical cord is in cervix or vagina.	
45. Feel the bag of water: intact, ruptured, amount, and color.	
46. Feel for presenting part, if the presenting part is the head; feel for position, caput/molding anterior and posterior fontanel.	
47. Smell examined glove fingers for odor, and look for discharge, blood, and meconium.	
48. Help the woman get into a comfortable position.	
49. Explain findings to the woman.	
50. Perform hand hygiene.	
51. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM ADMISSION OF A WOMAN IN LABOR

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

CHECKLIST 3: PHYSICAL EXAMINATION OF A PREGNANT WOMAN

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

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Learner _____

Date _____

CHECKLIST FOR PHYSICAL EXAMINATION OF A PREGNANT WOMAN	
STEP	SCORE
GETTING READY	
1. Greet the patient and relative respectfully.	
2. Verify the patient's identity.	
3. Provide privacy.	
4. Explain the procedure to the woman.	
5. Perform hand hygiene.	
PROCEDURE	
6. Palpate forehead for edema.	
7. Inspect conjunctiva for pallor.	
8. Inspect mouth for sore.	
9. Inspect tongue for pallor.	
10. Inspect for enlarge gland (goiter).	
11. Palpate for swollen lymph node.	
12. Palpate hand for edema.	
13. Palpate armpit for swollen lymph node.	
14. Inspect hands (palms) for pallor.	
15. Inspect nails bed for pallor.	
16. Inspect for flat nipples.	
17. Inspect for inverted nipples.	
18. Palpate for mass.	
19. Inspect for size.	
20. Inspect for shape.	
21. Inspect for surgical scar.	
22. Palpate for enlarge spleen and liver.	
23. Palpate and measure fundal height.	
24. Palpate for fetal back and limbs.	

CHECKLIST FOR PHYSICAL EXAMINATION OF A PREGNANT WOMAN	
STEP	SCORE
25. Palpate for fetus presentation.	
26. Auscultate for fetal heart tone.	
27. Genital Examination: Only if the woman states concern about her genitals, then perform an external examination for sores, swelling, bleeding, and abnormal discharge.	
28. Lower Extremities	
29. Inspect legs for deformity, abnormalities (symmetrical).	
30. Palpate for edema.	
31. Inspect nails bed for pallor.	
32. Inspect soles of feet for pallor.	
33. Inspect for varicose veins.	
34. Palpate for deep venous thrombosis.	
35. Back	
36. Ask woman to sit up.	
37. Palpate back for edema.	
38. Check for CVA tenderness.	
39. Do patellar reflex test.	
40. Explain to the woman your finding.	
41. Entertain questions from the woman.	
42. Properly discard all used materials.	
43. Perform hand hygiene.	
44. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM A PHYSICAL EXAM OF A PREGNANT WOMAN

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 3.1: ANTENATAL HISTORY TAKING

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

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Learner _____

Date _____

CHECKLIST FOR ANTENATAL HISTORY TAKING	
STEP	SCORE
GETTING READY	
1. Greet the patient and relatives respectfully.	
2. Verify the patient's identity.	
3. Clearly explain to the patient or relatives the purpose of history taking, and answer any questions.	
4. Assemble all needed materials on a tray and place it at the bedside.	
5. Ensure privacy.	
PROCEDURE	
6. Assist the patient into a comfortable position.	
7. Encourage the woman to ask questions and listen to what she has to say.	
8. Take history: Ask the woman how she is feeling and respond immediately to any urgent problem.	
9. Take social history: Name, age, address, marital status, job, level, of education, rest, finance, fear.	
10. Take medical history: Any major illness, e.g., diabetes, hypertension, TB, sickle cell.	
11. Take surgical history: C- section, or any surgery done.	
12. Take family history: Hypertension, diabetes, sickle cell, heart disease, epilepsy.	
13. Take obstetric history: GPATL.	
14. Ask about problems with last delivery/ pregnancy, retained placenta, pre-eclampsia, eclampsia, PPH, APH.	
15. Ask about assisted delivery: Vacuum delivery, C- Section, forceps, episiotomy.	
16. Ask breastfeeding history: Last breastfeeding, for how long.	
17. Ask about current pregnancy: LNMP, expected date of delivery.	
18. Ask about current pregnancy conditions: Vomiting, severe nausea, shortness of breath.	
19. Ask about malaria: Sanitation, bed nets (ITNs).	
20. Ask for danger signs, complaints, or concerns about pregnancy.	
21. Perform hand hygiene.	
22. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO CONDUCT ANTENATAL HISTORY TAKING

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (*in case of need to remediate or other*):

4: ANTENATAL CARE—FOCUSED ANTENATAL CARE GUIDE



Federal Ministry of Health, Nigeria

FOCUSED ANTENATAL CARE (FANC) GUIDE

	First visit (Less than 16 weeks)	Second visit (24-28 weeks)
GOALS ⇒	Confirm pregnancy and EDD Classify woman for basic or specialized care (if specialized, refer) Screen, treat and give preventive measures Develop a birth and emergency plan Advise and counsel	Assess maternal and fetal wellbeing Exclude PIH and anaemia Give preventive measures Review and modify birth and emergency plan Advise and counsel
ACTIVITIES		
Rapid assessment and management for emergency signs, give appropriate treatment and refer to hospital if needed.		
History (ask, check records)	Quick Check to assess significant symptoms Take identification, psychosocial, medical and obstetric history Confirm pregnancy (Check LMP and EDD) Classify woman (for Basic or Specialized care)-check test results if available	Quick Check to assess significant symptoms Check record for previous complications and treatment during the pregnancy Re-classify woman if needed
Examination (look, listen and feel)	Conduct complete general, obstetric and genital examination	Check for anaemia, BP , fetal growth and fetal movements
Screening and tests	Haemoglobin VDRL for syphilis HIV test Urinalysis for Proteinuria Blood/Rhesus group, Hb. Genotype Bacteriuria	Bacteriuria
Treatments	ARV if eligible Antibiotics for bacteriuria, if indicated	Benzathine benzyl- penicillin (2.4 million units IM stat), if VDRL test positive Anthelmintic for worms ARV if eligible Antibiotics for bacteriuria, if indicated
Preventive measures	1st dose of Tetanus toxoid Iron/Folate tablets	2nd dose of Tetanus toxoid Iron/Folate tablets 1st IPTp (3 tabs of SP) ARV if eligible
Health education, advice and counselling	Self-care, alcohol and tobacco use, nutrition, safe sex, rest, sleeping under ITN, IPT, HIV counseling and birth and emergency plan	Birth and emergency plan Reinforcement of previous advice

EDD=Estimated date of delivery, PIH=Pregnancy-induced hypertension, ARV=Antiretroviral drugs, ECV=External cephalic version, IPTp=Intermittent preventive treatment for malaria during pregnancy, ITN=Insecticide treated net, SP=Sulphadoxine-Pyrimethamine.

	Third visit 32 weeks	Fourth visit 36 weeks
GOALS ⇒	Assess maternal and fetal wellbeing Exclude PIH, anaemia, multiple pregnancy Give preventive measures Review and modify birth and emergency plan Advise and counsel	Assess maternal and fetal wellbeing Exclude PIH, anaemia, multiple pregnancy, malpresentation Give preventive measures Review and modify birth and emergency plan Advise and counsel
ACTIVITIES		
Rapid assessment and management for emergency signs, give appropriate treatment and refer to hospital if needed.		
History (ask, check records)	Quick Check to assess significant symptoms Check record for previous complications and treatment during the pregnancy Re-classify woman if needed	Quick Check to assess significant symptoms Check record for previous complications and treatment during the pregnancy Re-classify woman if needed
Examination (look, listen and feel)	Check for anaemia, BP, fetal growth and fetal movements	Check for anaemia, BP, fetal growth, fetal movements, multiple pregnancy and malpresentation
Screening and tests	Bacteriuria	Bacteriuria
Treatments	ARV if eligible Antibiotics for bacteriuria, if indicated	ARV, if eligible If breech, ECV or referral for ECV Antibiotics for bacteriuria, if indicated
Preventive measures	Iron/Folate tablets 2nd IPTp (3 tabs of SP) ARV if eligible	Iron/Folate tablets ARV if eligible
Health education, advice and counselling	Birth and emergency plan Infant feeding Postpartum/postnatal care Pregnancy spacing/Family planning Reinforcement of previous advice	Birth and emergency plan Infant feeding Postpartum/postnatal care Pregnancy spacing/Family planning Reinforcement of previous advice

EDD=Estimated date of delivery, PIH=Pregnancy-induced hypertension, ARV=Antiretroviral drugs, ECV=External cephalic version, IPTp=Intermittent preventive treatment for malaria during pregnancy, ITN=Insecticide treated net, SP=Sulphadoxine-Pyrimethamine.

SKILLS CHECKLIST ANTENATAL HISTORY, PHYSICAL EXAMINATION, AND BASIC CARE	
STEP/TASK	SCORE
GETTING READY	
1. Prepare the necessary supplies and equipment. (weighing scale, stethoscope, sphygmomanometer, fetoscope, measuring tape)	
2. Greet the woman respectfully and with kindness and introduce yourself.	
3. Tell the woman what is going to be done.	
4. Encourage the woman to ask questions and listen to what she has to say.	
HISTORY	
5. Ask the woman how she is feeling and respond immediately to any urgent problems.	
6. Ask the woman her name.	
7. Ask the woman her age.	
8. Ask the woman her obstetric history.	
9. Ask the woman her menstrual history.	
10. Ask the woman her contraceptive history.	
11. Ask if she has felt fetal movements.	
12. Calculate the EDD.	
13. Ask the woman about health problems. (medical and surgical history)	
14. Ask the woman about concerns related to her pregnancy. Ask about current genital swelling, sores, bleeding or discharge.	
15. Ask the woman about medications.	
16. Ask the woman about any care from another caregiver.	
17. Ask the woman if she smokes, drinks alcohol, or uses other potentially harmful substances.	
18. Ask the woman about her HIV status.	
19. Ask the woman if she has received tetanus toxoid immunization.	
20. Ask the woman about social support.	
PHYSICAL EXAMINATION	
21. Observe the woman's general appearance.	
22. Use antiseptic handrub or wash hands thoroughly with soap and water.	
23. Take the woman's blood pressure.	

¹ Write **C** if step or task is performed competently; write **N** if it is not performed competently

SKILLS CHECKLIST ANTENATAL HISTORY, PHYSICAL EXAMINATION, AND BASIC CARE	
STEP/TASK	SCORE
24. Check the woman's conjunctiva for pallor	
25. Examine her breasts for lumps and abnormal nipple discharge	
26. Examine abdomen and estimate fundal height (compare with gestational age).	
* After 36 weeks, determine presentation.	
27. Listen to the fetal heart (second and third trimesters).	
* Only if the woman states concern about her genitalia, perform an external examination for sores, swelling, bleeding, and abnormal discharge, wearing examination gloves on both hands.	
28. Perform infection prevention procedures. Dispose of gloves in contaminated waste container and washes and dries hands with a clean towel.	
Screening Procedures	
* If available, order VDRL, haemoglobin tests, and/or HIV test (if the woman consents to testing, after being counseled) and evaluate the results.	
CARE PROVISION	
* Treat the woman correctly for syphilis if the VDRL test is positive, provide counseling on safer sex, and discuss the need for her partner to be treated and counseled.	
29. Develop or review birth plan with the woman.	
30. Provide immunizations and preventive therapy, which may include: tetanus toxoid, iron/folate tablets, antimalarial tablets, mebendazole, and vitamin A (based on need and country/local policy).	
31. Provide counseling on danger signs and necessary topics.	
32. Ask the woman if she has any further questions or concerns.	
33. Thank the woman for coming.	
34. Tell the woman when she should come for her next antenatal visit.	

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5: BASIC HOSPITAL PROCEDURES–BED MAKING, ORAL CARE, BED BATH, HAIR AND BODY CARE, AND PATIENT'S POSITIONS OF COMFORT

Goal: By the end of these labs, the students will be able to demonstrate basic proficiency in performing essential hygiene techniques and will obtain a beginning understanding in the use of isolation and comfort techniques. These are primarily geared toward what they would need to know if required to assist in a hospital environment; however, they are also useful skills for providing care to patients in the community.

Key areas of concentration:

1. Occupied bed and bath to an individual with limitations to self-care such as: para- or quadriplegia, urinary incontinence, coma, depression and unwillingness to assist with self-care despite physical ability, alterations in skin integrity, obesity, cachexia (extreme weight loss), poor dental hygiene, fungal infections, diabetes, blindness, difficulty hearing, or fever.
2. Familiarity with bath, shampoo, and towel bath methods. Have students simulate a bed bath with their peers.
3. Ability to manipulate bed and place in various positions including Semi-Fowler's, High Fowler's, and Trendelenburg.
4. Application of appropriate safety measures given clinical scenario including bed position, side rails, call light and provision of elimination needs before leaving patient.
5. Use of appropriate medical asepsis techniques including order of bathing, use of gloves, care of linen and patient's immediate environment, and **handwashing**. For the last student in the group, add a situation in which the patient is on a specific type of isolation, requiring gowns and gloves, to challenge the group. Emphasize how to take off the used gown, not to walk around halls in isolation gowns (even if still clean), and the importance of handwashing even when wearing gloves.
6. Integration of assessment skills and planning and developing appropriate interventions while providing basic hygiene, e.g., the student notices that the paraplegic patient has difficulty moving about in bed and thus problem-solves and correctly identifies the needed measures. The students will need assistance and guidance, even suggestions, related to this.
- 18 Use of basic massage (hand, foot, back) as a comfort measure.
- 19 Use of hot and cold packs as comfort measure.

HYGIENE AND COMFORT CONTINUED

Equipment Needed

Bed Bath and Linen Station

- Bath items located in bedside table/drawer:
 - Bath basin
 - Soap and soap dish
 - Lotion
 - Emesis basin
 - Razor
 - Toothbrush
- 1 large plastic bag (not red bag) containing a fan folded bath blanket, bath towel, 2 or more washcloths
- Linen pack with the following:
 - 2 Towels
 - 2 Washcloth
 - 1 Bath blanket
 - 1 Linen bag
 - 1 Reusable bed pad
 - 2 Flat sheets
 - 1 Draw sheet
 - 1 Bedspread
 - 2 Pillowcases
 - 1 Patient gown
 - Clean gloves

Massage/Comfort Measure Station

- Copy of massage handouts
- Lotion or oil for massage

PERFORMANCE CHECKLIST FOR MAKING UNOCCUPIED BED

OBJECTIVE: Student will demonstrate competence in making an unoccupied bed by accurately completing all critical elements listed below.

EQUIPMENT:

- Bed
- Full set of Linen:
 - Pillowcase
 - Bedspread
 - Top sheet
 - Draw sheet
 - Bottom sheet
 - Linen bag
 - Optional: Blanket

PROCEDURE:

1. Wash hands.
2. Review client ambulation orders.
3. Obtain linen; place on client's chair or clean overhead table.
4. Explain procedure to client.
5. Assist client out of bed to chair.
6. Demonstrate good use of body mechanics by:
 - Raising bed to convenient working height; remove all attached equipment before raising bed.
 - Bend knees when pulling sheets.
 - Use longer, stronger muscles in arms to pull sheet tight.
 - Brace bed with knee or thigh when pulling sheet tight.
7. Lock wheels of bed.
8. Move around bed; loosen linen; avoid shaking.
9. Fold any linen to be reused into quarters and place on chair.
10. Place soiled linen directly into linen bag, not on floor.
11. Place bottom sheet on bed with center fold at center. Lower hem should be even with end of mattress at foot of bed. Tuck in sheet at head of bed. Miter the corner.
12. Remaining on same side of bed, obtain draw sheet and place over middle portion of bed with center fold at center. Tuck under mattress securely.
- *13. Continuing to remain on same side of bed, obtain top sheet. Place center fold at center of bed. Align top edge of sheet with top of mattress. Unfold it toward other side of bed.
14. Place spread on bed in same manner.
15. Make cuff at head of bed by folding back top sheet and spread approximately four (4) inches.
16. Make toe pleat; fold 2-inch pleat across bed about 6 inches from foot of bed.

17. Tuck sheet and spread firmly under mattress at foot of bed. Miter the corner.
18. Move to other side of bed. Pull and tuck under mattress each piece of linen starting with the bottom sheet, draw sheet, top sheet, and spread. Remember to miter the corners.
19. Apply clean pillowcase, avoiding contact with uniform.
20. Re-attach call bell.
21. Fan fold upper bedding to foot of bed.
22. Replace bedside stand so accessible to client.
23. Remove linen.
24. Assist client back to bed if desired or necessary.
25. Perform hand hygiene.
26. Document procedure and/or findings.

*It may be easier to apply and tuck in bottom and draw sheet on both sides first, then apply top sheet/spread.

PERFORMANCE CHECKLIST FOR MAKING OCCUPIED BED

OBJECTIVE: Student will demonstrate competence in making an occupied bed by accurately completing all critical elements listed below.

EQUIPMENT:

- Bed
- Full set of linen:
 - Pillowcase
 - Bedspread
 - Top sheet
 - Draw sheet
 - Bottom sheet
 - Linen bag

Optional: Blanket, bath blanket

PROCEDURE:

1. Follow Procedures 1–5 from Unoccupied Bed Making.
2. Raise bed rails and bed to comfortable working height and place head of bed flat, if tolerated.
3. Place bath blanket over client, pull top linens out from underneath. Place soiled linen in linen bag.
4. Assist client to roll to the opposite side where the nurse is standing, making sure bed rails are up on that side.
5. Lower bed rails of side where nurse is standing.
6. Loosen soiled linen on empty side of bed fold and tuck under client.
7. Tuck half of clean linen under client, underneath soiled linen.

8. Fanfold remaining half of sheet directly behind and parallel to patient's back.
9. Place draw sheet and linen savers, if necessary, centering and fan-folding the distal half behind and parallel to patient's back.
10. Assist the patient to roll to the other side over fan-folded linen, making sure side rails are up on patient's side.
11. Move to other side of bed, remove old sheet and pull through new sheet/draw sheets, linen savers.
12. Tuck top of sheet in, mitering corner. Tuck in remainder of sheet along the side of the bed.
13. Place the top sheet and bedspread over patient, centering it and folding approximately 2 inches of bedspread over top of sheet.
14. Tuck both sheet and bedspread in at bottom of bed; keep sheets loose or pleated to prevent plantar flexion and miter corners.
15. Assist client to comfortable position.
16. Replace call bell, lower bed, and raise side rails if necessary.
17. Place dirty linen in linen bags and place in laundry chute or dirty linen room.
18. Perform hand hygiene.
19. Document procedure and/or findings.

PERFORMANCE CHECKLIST FOR BED BATH

OBJECTIVE: Student will demonstrate competence in performing a bed bath by accurately completing all critical elements listed below.

EQUIPMENT:

- Bath blanket
- Two towels
- Washcloth
- Soap and soap dish or bath in a bag pack
- Bath basin
- Nail file
- Lotion
- Clean gown
- Bed linen
- Bed pan or urinal
- 2 4 X 4 gauze
- 1 Tongue blade
- 1 Emesis basin

GIVING A BED BATH

Recommended Techniques

1. Discuss procedure with client and assess client's ability in bathing process, as well as personal hygiene preferences. Review client's chart for limitations in physical activity.
2. Bring necessary equipment to bedside stand or over-bed table.
3. Close curtains around bed and close door to room if possible.
4. Offer client bedpan or urinal.
5. Wash your hands.
6. Raise client's bed to high position.
7. Lower side rail nearest to you. Assist client to side of bed where you will work. Have client lie on his/her back.
8. Loosen top covers and remove all, except top sheet. Place bath blanket over client and remove top sheet while client holds bath blanket in place. If linen will be reused, fold over chair. Place soiled linen in laundry bag.
9. Assist client with oral hygiene as necessary.
10. Remove client's gown and keep bath blanket in place. If client has IV, remove gown from other arm first. Lower intravenous container and pass gown over tubing and container. Re-hang container and check drip rate.
11. Raise side rail. Fill basin with warm water (between 43° C and 46° C, or 110° F and 115° F). Change as necessary throughout bath. To begin bath, lower side rail closest to you when you return to bedside.
12. On your hand, fold washcloth like a mitt. Make sure there are no loose ends.
13. Lay a towel across client's chest and on top of bath blanket.
14. With no soap on washcloth, wipe one eye from inner part of eye, near nose, to outer part. Rinse or turn cloth before washing other eye.
15. Bathe client's face, neck, and ears. Avoid soap on face if client prefers.
16. Expose the far arm of client and place towel lengthwise under it. Using firm strokes, wash arm and axilla. Rinse and dry.
17. Place a folded towel on bed next to client's hand and put basin on it. Soak client's hand in basin. Wash, rinse, and dry hand.
18. Repeat actions 16 and 17 for arm nearer to you.
19. Spread a towel across client's chest. Lower bath blanket to client's umbilicus area. Wash, rinse, and dry client's chest. Keep client's chest covered with the towel between wash and rinse. Pay special attention to skin folds and under breasts of client.
20. Lower bath blanket to client's perineal area. Place towel over client's chest.
21. Wash, rinse, and dry client's abdomen. Carefully inspect and cleanse umbilical area and any abdominal folds or creases.
22. Return bath blanket to original position and expose far leg of client. Place towel under far leg. Using firm strokes, wash, rinse, and dry client's leg from ankle to knee and knee to groin.

23. Fold towel near client's foot and place basin on it. Place client's foot in basin while supporting ankle and heel in your hand and leg in your arm. Wash, rinse and dry, paying attention to area between toes.
24. Repeat actions 22 and 23 for other leg and foot.
25. Make sure client is covered with bath blanket. Change water at this point or earlier if necessary. Assist client onto side.
26. Assist client to prone or side-lying position. Position bath blanket and towel to expose only back and buttocks.
27. Wash, rinse, and dry client's back and buttocks area. Pay attention to cleansing between gluteal folds and observe for any indication of redness or skin breakdown in the sacral area.
28. If not contraindicated, give client a backrub, as described in procedure 32-1. Back massage may also be given after perineal area is washed.
29. Refill basin with clean water. Discard washcloth and towel.
30. Clean client's perineal area or set up client so he can complete perineal self-care.
31. Help client put on a clean gown and attend to personal hygiene needs.
32. Protect the pillow with a towel and groom the client's hair.
33. Change bed linens.
34. Perform hand hygiene.
35. Document procedure and/or findings.

ADMINISTERING A TOWEL BATH

GOAL: To bathe a patient with dementia who may resist a tub bath or shower.

EQUIPMENT NEEDED:

- 1 Or more bath blankets
- 1 Large plastic bag containing:
- 1 Large towel or bath blanket (fan folded)
- 1 Bath towel
- 2 Or more wash cloths
- 2- to 3-qt. plastic basin filled with water (105°–110° F) with 1 to 1½ oz. no-rinse soap

RECOMMENDED TECHNIQUE:

1. Identify and greet the patient. Decrease stimulation by (make the room quiet, play soft music, dim lights) to calm the patient. Ensure privacy.
2. Wash your hands.
3. Place 1 bath blanket under the patient, if needed, to protect the linen and keep patient warm.
4. Undress the patient, keeping him covered with bed linen or second bath blanket. Protect the covering linen, if needed, by folding it at the end of the bed.
5. Pour the soapy water into the plastic bag, until towels and washcloths are uniformly damp. Wring out excess solution from open end of the bag into the sink. Twist top of bag closed to retain heat, and take bag with towels and washcloths to bedside.

6. Expose the patient's feet and lower legs, and immediately cover area with the large, warm, moist towel. Gently and gradually uncover the person while unfolding the wet towel to cover him. Place covers at the end of the bed.
7. Start washing at whatever part of the body is least distressing to the patient. Place bath blanket over the towel to hold in the warmth, if you wish. Wash the back of the legs by bending the knees and going underneath. Bathe the face, neck, and ears with a washcloth. If preferred, hand the patient a washcloth and encourage him to wash his face.
8. Turn person to one side, placing the smaller warm towel on the back. No rinsing or drying is necessary. Use a wash cloth to wash the genital and rectal areas (wearing gloves at this time). Remove the large damp towel before washing the back, or when the bath is over, depending on the patient's wishes and tolerance.
9. Keep patient covered with bath blanket and bed linen, if he prefers to be dressed at a later time.
10. Place used linen back into the plastic bag; tie bag, and place in a hamper.
11. Perform hand hygiene.
12. Document procedure and/or findings.

Adapted from: Rader J, et al. The Bathing of Older Adults with Dementia. *American Journal of Nursing* 2006;106(4): 40–48.

PROCEDURE: BATHING AN INFANT

OBJECTIVE: Student will demonstrate competence in bathing an infant by accurately completing all critical elements in the procedure.

EQUIPMENT:

- Basin
- Washcloth
- Water
- Shampoo/Soap
- Bath blanket
- Comb/Brush
- Towel

RECOMMENDED TECHNIQUE:

1. Gather equipment, keep room temperature warm and free of drafts, and keep water warm (100°).
2. Wash hands.
3. Wash face with water (may hold infant in football hold or lay infant down; always keep one hand on infant at all times).
4. Using football hold, wash hair.
5. Dry face and hair with towel.
6. If baby has crusted material around eyes, clean with cotton swab soaked in water. If nostrils require further cleaning, use soaked Q-tips.

7. Remove clothes/diaper, keeping areas not being washed unexposed to prevent heat loss.
8. Wash and rinse infant's body, paying special attention to genitalia and buttocks.
9. Dry well (especially between skin folds).
10. Replace diaper and dress in clean T-shirt.
11. Return equipment to proper storage area.
12. Perform hand hygiene.
13. Document procedure and/or findings.

MOVING A CLIENT UP IN BED (ONE NURSE)

RECOMMENDED TECHNIQUE:

1. Explain procedure to client.
2. Wash your hands.
3. Raise bed to comfortable position for you. Adjust bed to flat position if client can tolerate it. Lower side rail nearest you.
4. Remove pillow and place at head of bed.
5. If able to assist, have client flex knees with feet flat on bed.
6. Assist client to grasp overhead trapeze bar, or if unable to assist, fold client's arms across chest.
7. Instruct client to flex neck with chin on chest.
8. Stand opposite client's center with your feet spread and turned toward head of bed. Position one foot slightly forward.
9. Flex knees and hips. Place one arm under client's neck and shoulders, grasping the far shoulder with your hand. Place your other arm under the client's upper thighs. Pull client closer to your side of bed. Move client's head and legs to alignment.
10. Review plan of movement with client. Tighten your abdominal and gluteal muscles.
11. Shift your weight back and forth from back leg to front leg, and on the count of three, move client upward in bed. If possible, client should push with legs and assist movement upward by grasping trapeze. Repeat if necessary.
12. Assist client to comfortable position in center of bed. Reposition pillow. Raise side rail to adjust bed position, if necessary.
13. Perform hand hygiene.
14. Document procedure and/or findings.

TURNING A CLIENT IN BED

RECOMMENDED TECHNIQUE:

1. Explain procedure to client.
2. Wash your hands.

3. Raise bed to waist level and adjust to flat position or as low as client can tolerate. Lower side rail near you and raise opposite rail.
4. Position client closer to far side of bed in supine position.
5. Place client's arms across the chest and cross client's far leg over the near one.
6. Stand opposite client's center with your feet spread and one foot ahead of the other. Tighten gluteal and abdominal muscles and flex knees.
7. Position hands on client's far shoulder and hip and roll client toward you.
8. Make client comfortable and position in proper alignment.
9. Readjust bed height and position and raise side rail if appropriate.
10. Perform hand hygiene.
11. Document procedure and/or findings.

CHECKLIST 6: BIMANUAL COMPRESSION

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR BIMANUAL COMPRESSION	
STEP	SCORE
GETTING READY	
1. Explain the present situation to the woman and inform her about the procedure.	
2. Call for help.	
3. Ensure that her bladder is empty.	
4. Place the woman in a comfortable position.	
PROCEDURE	
5. Massage uterus until it is contracted and bleeding slows.	
6. If bleeding does not slow, perform external bimanual compression.	
7. Give oxytocin or ask assistant to give oxytocin.	
8. Place one hand on the abdomen and behind the uterus.	
9. Place other hand below on abdominal wall just above symphysis.	
10. Press your hands together squeezing the uterus until bleeding slows for 10–20 minutes.	
11. If bleeding does not slow, repeat oxytocin and start IV infusion.	
12. If bleeding slows or stops; check for bleeding, contracted uterus, full bladder every 15 minutes X 2 hours, then every 30 minutes X 2 hours.	
13. Take vital signs, estimate blood loss, and record information.	
14. Give broad spectrum antibiotics.	
15. Encourage breastfeeding, and watch for complications.	
16. Refer; if unable to refer, observe for 48 hours.	
17. If bleeding does not stop or slow, do internal bimanual compression.	
18. Ask an assistant to start IV infusion with oxytocin and take vital signs.	
19. Look for signs of shock.	
20. Rub uterus again to make uterus contract.	
21. If uterus is not contracting and if bleeding is not slowed or stopped, insert your freshly gloved examining hand into vagina.	
22. Gently slide index and middle fingers into uterus through the cervix.	
23. Gather all clots and tissues, and remove your hand from uterus.	
24. If bleeding continues, form your hand into a fist and press against lower portion of the uterus.	

CHECKLIST FOR BIMANUAL COMPRESSION	
STEP	SCORE
25. Put constant downward and forward pressure with your abdominal hand.	
26. Press abdominal hand and your fist together for 5–10 minutes. Look for bleeding.	
27. If uterus contracts and bleeding slows or stops, remove hand.	
28. Continue to monitor contracted uterus, vital signs, breastfeeding during referral.	
29. If bleeding does not stop or slow, remove your hand.	
30. Continue external bimanual compression during referral.	
31. Monitor vital signs.	
32. Get family and blood donors.	
33. Do not stop bimanual compression until you get to a doctor.	
34. Explain to woman your finding.	
35. Entertain questions from woman.	
36. Properly discard all used materials.	
37. Properly remove and dispose of gloves, if any.	
38. Perform hand hygiene.	
39. Document procedure and/or findings: vital signs, IV infusion, condition of placenta and membranes, estimated blood loss, amount of oxytocin.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM BIMANUAL COMPRESSION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 7: BLADDER IRRIGATION

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR BLADDER IRRIGATION	
STEP	SCORE
GETTING READY	
1. Greet the patient and relatives respectfully.	
2. Verify order: Check the patient’s chart for physician’s order.	
3. Verify the patient’s identity.	
4. Clearly explain to the patient or relatives the purpose of irrigation, and answer any questions.	
5. Assemble all needed materials on a tray.	
6. Ensure the patient’s privacy.	
7. Place the patient in a comfortable position.	
PROCEDURE	
8. Perform hand hygiene.	
9. Put on disposable gloves.	
10. Clean the irrigation inlet arm of the catheter with antiseptic solution.	
11. Insert the irrigation set connector into the cleansed inlet of the catheter.	
12. Attached the urine bag if a drainage bag is not already in use.	
13. Open the valve of the irrigation set and regulate the flow to a prescribe rate.	
14. Renew the irrigating fluid as stated on patient’s prescription and empty the drainage bag.	
15. Ensure that the patient is left feeling as comfortable as possible.	
16. Properly discard all used materials.	
17. Properly remove and dispose of gloves.	
18. Perform hand hygiene.	
19. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM BLADDER IRRIGATION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 8: BLOOD TRANSFUSION

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR BLOOD TRANSFUSION	
STEP	SCORE
GETTING READY	
1. Greet the patient and relatives respectfully.	
2. Verify the patient’s identity, blood type, and allergies.	
3. Explain to the patient or relatives the purpose of blood transfusion, answer questions, and obtain consent.	
4. Prepare tray and assemble all materials.	
5. Perform hand hygiene.	
6. Put on gloves.	
PROCEDURE	
7. Take vitals and record.	
8. Flush infusion tubing to remove air, connect it to blood bag, and place it on IV pole.	
9. Select and prepare the vein puncture site.	
10. Uncap and insert the appropriate size of cannula or butterfly into the vein.	
11. Observe for back flow of blood, remove needle, release tourniquet, and forward insert the cannula or butterfly, and flush with saline.	
12. Secure cannula or butterfly with adhesive tape.	
13. Attach infusion tubing or spigot.	
14. Hang the blood and squeeze the chamber.	
15. Open the blood line clamp.	
16. Regulate the appropriate flow rate according to physician order.	
17. Ensure proper disposal of waste; place needle in sharps container and other waste in medical waste container.	
18. Monitor patient for the first 5–10 minutes, and record vital signs.	
19. Continue monitoring tolerance and take vitals again at 30 minutes and document.	
20. Perform hand hygiene.	
21. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM BLOOD TRANSFUSION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 9.1: SUPPORTING SUCCESSFUL BREASTFEEDING

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR SUPPORTING SUCCESSFUL BREASTFEEDING	
STEP	SCORE
GETTING READY	
1. Greet the mother.	
2. Include the family in discussion of breastfeeding if possible.	
3. Ask the mother if there is any reason she cannot breastfeed.	
4. Explain why it is important to breastfeed soon after birth.	
5. Perform hand hygiene with soap and water and dry with a clean, dry cloth or allow to air dry.	
HELP THE MOTHER AND BABY START BREASTFEEDING	
6. Explain each step as it is done so the mother can do it herself.	
7. Mother's position: <ul style="list-style-type: none"> Help the mother into a comfortable position. 	
8. Baby's position: <ul style="list-style-type: none"> Place baby close to the mother. Ensure that head and body are in a straight line. Ensure that the baby is facing breast with nose close to the nipple. Ensure that whole body is fully supported. Put baby on a blanket or pillow (if needed), so the baby and breast are at the same level. 	
9. Perform hand hygiene.	
10. Document procedure and/or findings.	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO SUPPORT SUCCESSFUL BREASTFEEDING

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

CHECKLIST 10: CARDIOPULMONARY RESUSCITATION

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR CARDIOPULMONARY RESUSCITATION	
STEP	SCORE
GETTING READY	
1. Approach the patient, check for response with gentle shake, and ask if okay.	
2. Call for help.	
PROCEDURE	
3. Place the patient in a safe position (flex the neck to open airway).	
4. Check for breathing.	
5. Give two breaths (1 second each).	
6. Check carotid pulse.	
7. Locate CPR hand position (2 finger breadths above xyphoid process).	
8. Deliver first cycle of compressions (<23 seconds for 30 compressions).*	
9. Open airway, give two breaths.	
10. Deliver second cycle of compressions.	
11. Open airway, give two breaths.	
12. Deliver third cycle of compressions.	
<i>Stop test and determine if student passes or does not pass. Continue in real life, depending on spontaneous breathing and pulse returning. If another person comes, may assist with breaths or compressions.</i>	
13. Perform hand hygiene.	
14. Document procedure and/or findings.	
TOTAL	

*per the American Heart Association

Learner IS ☐ QUALIFIED ☐ NOT QUALIFIED TO PERFORM CPR

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

CHECKLIST 11.1: CATHETERIZATION (FEMALE)

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

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Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR CATHETERIZATION (FEMALE)	
STEP	SCORE
GETTING READY	
1. Greet the patient and relatives respectfully.	
2. Verify order: Check the patient's chart for physician's order.	
3. Verify the patient's identity.	
4. Explain to the patient or relatives the purpose of the catheterization, the procedure, and answer questions.	
5. Assemble all needed materials on a tray.	
6. Perform hand hygiene.	
7. Put on gloves.	
PROCEDURE	
8. Provide privacy.	
9. Assist the client into a supine position, with the knees slightly flexed and both thighs slightly apart.	
10. Drape the client by folding the top bed cloth down so that the vagina is exposed and the thighs are covered.	
11. Percuss and palpate the bladder to assess for urinary retention.	
12. Inspect the urinary meatus for swelling and presence of discharge.	
13. Wash the perineal area with warm water and mild soap using the non-dominant hand; separate the labia majora with the thumb and finger, and clean the labia minora on each side using forceps and cotton balls/ swab.	
14. Move downward from the pubic area to the anus.	
15. Once the meatus is cleaned, do not allow the labia to close over it to prevent contamination.	
16. Remove examination glove and dispose of properly.	
17. Create a sterile field, and put on sterile gloves.	
18. Insert the catheter by placing the drainage in the urine receptacle; pick up the insertion end of the catheter with your uncontaminated, sterile gloved hand, holding it about 8–10 cm from the insertion tip.	
19. Separate the labia and insert the catheter gently into the urethral meatus, holding the catheter about 5 cm from the insertion tip until urine begins to flow into the attached urine bag.	

CHECKLIST FOR CATHETERIZATION (FEMALE)	
STEP	SCORE
20. If resistant is met while inserting the catheter, do not use force, ask the patient to take in deep breaths, then continue until back flow is observed.	
21. Inflate the balloon of the catheter with appropriate volume of fluid indicated on the catheter.	
22. Tape the drainage bag tubing on the patient's thigh.	
23. Remove and dispose of gloves properly.	
24. Perform hand hygiene.	
25. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM CATHETERIZATION ON A FEMALE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 11.2: CATHETERIZATION (MALE)

(To be completed by the **Assessor**)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR CATHETERIZATION (MALE)	
STEP	SCORE
GETTING READY	
1. Greet the patient and relatives respectfully.	
2. Verify order: Check the patient's chart for physician's order.	
3. Verify the patient's identity.	
4. Explain to the patient or relatives the purpose of the catheterization, the procedure, and answer questions.	
5. Assemble all needed materials on a tray.	
6. Perform hand hygiene.	
7. Put on gloves.	
PROCEDURE	
8. Provide privacy.	
9. Assist the client to a supine position, with the knees slightly flexed and both thighs slightly apart.	
10. Drape the client by folding the top bed cloth down so that the penis is exposed and the thighs are covered.	
11. Pull back the foreskin if there is one present and insert the catheter gently into the urethra through the meatus; hold the catheter about 5 cm from the insertion tip until urine begins to flow into the attached urine bag.	
12. If resistant is met while inserting the catheter, do not use force, ask the patient to take in deep breaths, then continue until back flow is observed.	
13. Inflate the balloon of the catheter with appropriate volume of fluid indicated on the catheter.	
14. Tape the drainage bag tubing on the patient's thigh (<i>replace foreskin if present, otherwise could cut off circulation</i>).	
15. Remove and dispose of gloves properly.	
16. Perform hand hygiene.	
17. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM CATHETERIZATION ON A MALE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 11.3: SAMPLE POLICY AND PROCEDURE INSERTION, REMOVAL AND CARE OF AN INDWELLING FOLEY CATHETER

SAMPLE Policy and Procedure Insertion, Removal and Care of an Indwelling Foley Catheter

Approved by: Policy and Procedure Committee
Effective: x/xx
Revised: x/xx

Description: This policy provides the procedure to ensure the safe, sterile placement and removal of the Foley catheter. It also provides guidelines for catheter care and specimen collection from the catheter.

Accountability: The physician is responsible for writing the order for placement of the Foley catheter. The registered nurse, licensed practical nurse, advanced care partner, emergency medical technician or paramedic is responsible for placing an indwelling urinary catheter (Foley catheter). The above personnel must have demonstrated the knowledge and skills to perform this procedure as evidenced by verification on a competency checklist.

Instructions for Specialty Temperature Sensing Foley: If temperature sensing foleys are clinically indicated, they are to be utilized in the Operating Room, Emergency Department and Critical Care Units only. Temperature sensing foleys are NOT MRI compatible. If a patient is to receive an MRI scan, the temperature sensing foley catheters MUST be removed and a non temperature sensing foley is to replace it prior to leaving the clinical area for the MRI scan.

Policies/Procedures:

1. **Identify the patient using the required two patient identifiers.**
2. Verify that the patient is not allergic to latex, iodine or betadine. If the patient is sensitive or allergic to latex, replace the catheter in the kit with a silicone catheter. If the patient is allergic to iodine or betadine, use an alternate cleanser such as Hibiclens.
3. Gather equipment: Foley catheter kit (use non-latex for patients with latex allergies). Use the smallest size catheter that is appropriate.
4. Explain the procedure to the patient and wash your hands **or perform hand hygiene**. Maintain the patient's privacy and dignity.
5. **Consider washing the patient's genital area before the procedure if visibly soiled. Don non-sterile gloves, wash patient's genital area thoroughly with foam body cleanser (4:1 body cleanser) or Ready cleanse™ wipes Remove gloves and wash hands/hand hygiene.**
6. General Insertion Procedures
 - a. Visually inspect the product for any imperfections or surface deterioration prior to use. If any damage is noted or the package has been opened, do not use.
 - b. **Don protective eye wear**
 - c. **Using aseptic technique, open the outer plastic wrap to form a sterile field and place the underpad beneath the patient, plastic side down.**
 - d. Position the sterile fenestrated drape around the patient's genitalia.

Insertion, Removal and Care of an Indwelling Foley Catheter

- e. **Apply sterile gloves and use strict sterile technique for the foley insertion procedure.**
 - f. Before insertion, dispense the lubricating gel into the kit tray, pour cleansing solution over three cotton balls, remove the plastic sleeve from the catheter and lock the sterile water syringe into the port. **DO NOT PRE-INFLATE THE BALLOON PRIOR TO INSERTION.**
 - g. Using the dominant, sterile hand to handle the catheter, cover the tip of the catheter with lubricant. Insert the foley through the urethra into the bladder.
 - h. Instruct the patient to inform the nurse if any discomfort is felt with inflation of the balloon. If discomfort is felt, the catheter is most probably in the urethra and will need to be deflated and advanced. Inflate the balloon slowly, using the entire 10 cc of sterile water. Withdraw the catheter slowly to the point of resistance at the bladder neck.
7. Female Insertion Procedure
- a. Position female patient into a frog-leg pose.
 - b. Separate the labia using the non-dominant hand and visualize the meatus. Grasp one cotton ball with the forceps, wipe one side of the labia from top to bottom and discard the cotton ball away from the sterile field. Repeat on the opposite side and then wipe down the middle using the third cotton ball. Then wipe the area with the dry cotton balls.
 - c. Insert the catheter approximately three inches, wait to see if urine flows, then advance another inch before inflating balloon.
 - d. For unconscious female patient's or those with decreased sensation (i.e. paralyzed), insert the catheter slightly further than three inches, to make certain the catheter is in the bladder.
8. Male Insertion Procedures
- a. Position male patients into a supine pose.
 - b. Retract the foreskin, if present, and hold the shaft of the penis with the non-dominant hand. Grasp one solution-soaked cotton ball with the forceps. Using a circular motion, wipe the glans from the meatus outward. Discard the cotton ball away from the sterile field. Repeat with two more cotton balls. Then wipe the area dry with the dry cotton balls.
 - c. Grasp the penis in an upright position and insert the lubricated catheter firmly into the meatus, advancing the catheter to the bifurcation at the 'Y' of the catheter. A slight lean toward the umbilicus may be necessary if resistance in advancing the catheter is met at the prostate.
 - d. The return of urine does not assure that the catheter is placed correctly in males, since there is residual urine in the penis. Inserting the catheter to the bifurcation of the Y is the standard for assurance of proper placement.
 - e. If the foreskin was retracted, reposition it after placement.
 - f. **If catheter placement is in question (i.e. no urine return or unable to fully insert the catheter) do not inflate the balloon and contact the physician.**
 - g. **If resistance is met do not attempt forceful catheter insertion; apply continuous gentle pressure and ask the patient to take slow deep breaths to help relax or instruct the patient to try to void to open the sphincter and allow the catheter to pass.**

Insertion, Removal and Care of an Indwelling Foley Catheter

9. Complete the procedure
 - a. **Secure the catheter to the patient's thigh with hospital approved catheter securement device (ie: Stat Lock) to prevent movement, irritation, and decrease risk of infection.** To improve urine flow, some men may need to have the catheter secured slightly upward. For males with long-term catheters, the catheter should be taped to the abdomen to prevent damage to the inferior urethra.
 - b. **Position the bag to avoid urine reflux into the bladder, kinking, or gross contamination of the bag.** For inpatient setting, position the bag hanger on the bed rail near the foot of the bed using the clip to secure the drainage tube to the sheet. **Keep the bag below the level of the bladder at all times to prevent the backflow of urine and decrease the risk for infection.** Never leave the catheter hanging to be pulled by the weight of the bag **Do not leave the bag laying on the floor unless necessary due to patient positioning (i.e. trendelenburg position in the Operating Room).**
 - c. Periodic observations of the system should be made to ensure that urine is flowing freely. If a standing column of urine is observed, check for correct positioning of the bag and then for a physical obstruction, such as a kink in the tubing.
 - d. If correct positioning of the bag or removal of physical obstruction does not allow free flow, the bag may have to be changed.
10. Directions for removal
 - a. Deflate the catheter balloon by negative pressure.. Exercise the plunger of a leur-tipped 10 ml syringe by moving up and down within the syringe barrel. Pull back 0.5 ml air in the syringe to prevent adherence of the plunger to the end of the syringe barrel, then insert the syringe into the balloon port. (This allows for automatic flow of instilled liquid and balloon deflation via negative pressure in the syringe.) Never use more force than is required to make the syringe "stick" in the valve. Use gentle aspiration, only if needed, to encourage deflation.
 - b. Allow the pressure within the balloon to push the plunger back and fill the syringe with water.
 - c. **NEVER FORCE THE WATER INTO THE SYRINGE.** Vigorous aspiration may collapse the inflation lumen, preventing balloon deflation. Allow 30 seconds for the balloon to deflate.
 - d. If there is slow or no deflation, re-seat the syringe gently.
 - e. If the retention balloon still does not deflate, reposition the patient to ensure catheter is not in traction or compressed within the bladder.
 - f. If this fails, contact the charge RN and the physician.
 - g. **Consider a bedside commode if the patient is not fully ambulatory.**
11. Directions for bladder scanning:
 - a. **If the patient does not void within 4-6 hours of removing the foley catheter, a bedside bladder scan ultrasound should be obtained.**
 - b. **If the bladder volume is less than 500mL, encourage the patient to void by using techniques to stimulate bladder reflex (cold water to abdomen, stroke inner thigh, run water, flush toilet). Continue to assess the patient and repeat the bladder scan in 2 hours if the patient has not voided.**
 - c. **If the bladder volume is greater than 500mL, catheterize for residual urine volume rather than place an indwelling foley catheter.**

Insertion, Removal and Care of an Indwelling Foley Catheter

12. Patient care and considerations
 - a. **Always use sterile technique when inserting a foley catheter.**
 - b. Document the following:
 1. procedure, including the size of the catheter placed, the color, amount, and clarity of urine returned after the initial placement, and patient response.
 2. Catheter removal
 3. Use of the bladder scanner, amount of residual volume, need for intermittent catheterization.
 - c. Record urine output as ordered.
 - d. Assess the patient for pain during and after procedure. Provide pain relief measures as indicated and document response.
13. Infection control considerations
 - a. Wash hands or perform hand hygiene immediately before and after any manipulation of the catheter site or drainage bag.
 - b. **Clean the perineal area and catheter tubing proximal to distal, with foam body cleanser (4:1 body cleanser) or Ready cleanse™ wipes daily and after every bowel movement. The meatal area should not be aggressively cleansed or cleansed with antiseptic solutions as this can lead to meatal aggravation and increase the likelihood of infection.**
 - c. **If a foley catheter has been in place for 3 days or longer, the nurse should provide daily reminders to the physician recommending the removal of the foley catheter (unless the foley catheter is still indicated). Indications for continued foley usage include: unresolved urinary retention, urinary tract obstruction, critically ill patients, acute renal insufficiency fluid challenge, comfort care of the terminally ill, to promote healing on an area of skin breakdown, to provide medications directly to the bladder, and for the management of neurogenic bladder.**
 - d. **Provide patient and family education regarding the benefits of removing the foley. Encourage use of the bedside commode or bathroom within 4-6 hours after the foley is removed.**
 - e. **To obtain a urine specimen, clean the sample port with alcohol and aspirate urine using a blunt needle (or leur lock syringe) and a 10 cc syringe.**
 - f. A sterile, continuously closed drainage system should be maintained. If the catheter must be disconnected from the tubing, disinfect the catheter-tubing junction before separating.
 - g. **Empty the foley bag every 8 hours, or when the drainage bag is 2/3 full, to avoid traction on the catheter from the weight of the drainage bag and prevent infection. Take care not to contaminate the drainage port by touching the collection container or floor when emptying.**
 - h. **When transporting patient, maintain position of drainage bag below the level of the patient's bladder, to prevent reflux of contaminated urine from the bag to the bladder. Transport personal should be instructed to wash their hands prior to transporting a patient with a foley catheter. The catheter bag should be empty prior to transport to prevent reflux.**
 - i. **If possible do not place more than one patient with a urinary catheter in the same room to prevent cross contamination.**

Insertion, Removal and Care of an Indwelling Foley Catheter

- j. If foley catheter is to remain indwelling for 30 days, obtain an order for foley catheter and bag change at 30 day intervals.
- k. Do not irrigate a foley catheter unless indicated for post urology /genitourinary trauma, surgery, or in the ICU to relieve obstruction.

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1. Ackley, B.J., Ladwig, G.B., Swan, B.A. & Tucker, S.J. (2008). Evidence-Based Nursing Care Guidelines: Medical Surgical Interventions. St. Louis: Mosby Elsevier. (Level VI)
2. Apisarnthanarak, A., et al. (2006). Effectiveness of multifaceted hospitalwide quality improvement programs featuring an intervention to remove unnecessary urinary catheters at a tertiary care center in Thailand. *Infection Control and Hospital Epidemiology*, 28 (7), 791-798. (Level V)
3. BARD Instructional Video. Preventing UTI: Care and Catheterization Techniques. 2004. (Level VI).
4. Crouzet, J., Bertrand, X., Venier, A. G., Badoz, M., Husson, C., & Talon, D. (2007). Control of the duration of urinary catheterization: impact on catheter-associated urinary tract infection. *Journal of Hospital Infection*, 67, 253-257. (Level III)
5. Gray, M. (2004). What nursing interventions reduce the risk of symptomatic urinary tract infection in the patient with an indwelling catheter? *Journal of the Wound, Ostomy and Continence Nurses*, 31 (1), 3-13.(Level VI)
6. Lee, Y. Y., Tsay, W. L., Lou, M. F., & Dai, Y. T. (2006). The effectiveness of implementing a bladder ultrasound program in non-surgical units. *Journal of Advanced Nursing*, 57 (2), 192-200. (Level III)
7. Lo, E., et al. (2008). Strategies to prevent catheter-associated urinary tract infections in acute care hospitals. *Infection Control and Hospital Epidemiology*, 29 (supplement 1), S41-S50. (Level I)
8. Netina, S. M. (Ed.). (2006). Lippincott Manual of Nursing Practice, 8th ed. New York: Lippincott Williams and Wilkins. (Level VI)
9. Newman, D. K. (2007). The indwelling urinary catheter-principles for best practice. *Journal of the Wound, Ostomy and Continence Nurses Society*, 34 (6), 655-661. (Level VI)
10. Robinson, S. et al. (2007). Development of an evidence-based protocol for reduction of indwelling urinary catheter usage. *MedSurg Nursing*, 16 (3), 157-161. (Level VI)
11. Society of Urologic Nurses and Associates (SUNA) Clinical Practice Guidelines Task Force. (2006). Care of the patient with an indwelling catheter. *Urologic Nursing*, 26(10): 80-81. (Level VI)

CHECKLIST 12: CERVICAL LACERATION REPAIR

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR REPAIR OF CERVICAL LACERATION	
STEP	SCORE
GETTING READY	
1. Prepare the necessary equipment.	
2. Tell the woman (and her support person) what is going to be done, listen to her, and respond attentively to her questions and concerns.	
3. Provide continual emotional support and reassurance, as feasible.	
4. Have the woman empty her bladder or insert a catheter.	
5. Give anesthesia, if necessary.	
6. Put on PPE.	
REPAIR OF CERVICAL TEARS	
7. Perform hand hygiene and put on high-level disinfected or sterile gloves.	
8. Clean the vagina and cervix with an antiseptic solution.	
9. Grasp both sides of the cervix using ring or sponge forceps (one forceps for each side of tear).	
10. Place the first suture at the top of the tear and close it with a continuous suture, including the whole thickness of the cervix each time the suture needle is inserted.	
11. If a long section of the rim of the cervix is tattered, under-run it with a continuous suture.	
12. Use ring forceps if the apex is difficult to reach and ligate.	
POSTPROCEDURE TASKS	
13. Before removing gloves, dispose of waste materials in a leak-proof container or plastic bag.	
14. Place all instruments in 0.5% chlorine solution for decontamination.	
15. Remove gloves and discard them in a leak-proof container or plastic bag if disposing of or decontaminate in 0.5% chlorine solution them if reusing.	
16. Perform hand hygiene.	
17. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM CERVICAL LACERATION REPAIR

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 14.1: BREECH DELIVERY

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR BREECH DELIVERY	
STEP	SCORE
GETTING READY	
1. Prepare the necessary equipment.	
2. Tell the woman (and her support person) what is going to be done, listen to her, and respond attentively to her questions and concerns.	
3. Provide continual emotional support and reassurance, as feasible.	
4. Ensure that the conditions for breech delivery are present.	
5. Put on personal protective equipment.	
PREPROCEDURE STEPS	
6. Use antiseptic handrub or perform hand hygiene and put on high-level disinfected or sterile gloves.	
7. Clean the vulva with antiseptic solution.	
8. Catheterize the bladder, if necessary.	
BREECH DELIVERY	
Delivery of the Buttocks and Legs	
9. When the buttocks have entered the vagina and the cervix is fully dilated, tell the woman she can bear down with contractions.	
10. Perform an episiotomy, if necessary.	
11. Let the buttocks deliver until the lower back and shoulder blades are seen.	
12. Gently hold the buttocks in one hand.	
13. If the legs do not deliver spontaneously, deliver one leg at a time.	
14. Hold the newborn by the hips.	
Delivery of the Arms	
15. If the arms are felt on the chest, allow them to disengage spontaneously.	
16. If the arms are stretched above the head or folded around the neck, use Lovset's maneuver.	
17. If the newborn's body cannot be turned to deliver the arm that is anterior first, deliver the arm that is posterior.	

CHECKLIST FOR BREECH DELIVERY	
STEP	SCORE
Delivery of the Head	
18. Deliver the head using the Mauriceau Smellie Veit maneuver.	
19. Complete steps for active management of the third stage of labor.	
20. Following childbirth, check the birth canal for tears and repair, if necessary. Repair the episiotomy, if one was performed.	
21. Provide immediate postpartum and newborn care, as required.	
POSTPROCEDURE STEPS	
22. Before removing gloves, dispose of waste materials in a leak-proof container or plastic bag.	
23. Place all instruments in 0.5% chlorine solution for decontamination.	
24. Remove gloves and discard them in a leak-proof container or plastic bag if disposing of or decontaminate them in 0.5% chlorine solution if reusing.	
25. Perform hand hygiene.	
26. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM BREECH DELIVERY

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 14.2: CONDUCTING DELIVERY OF FACE PRESENTATION (MENTO-ANTERIOR)

(To be completed by the **Assessor**)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR CONDUCTING DELIVERY OF FACE PRESENTATION (MENTO-ANTERIOR)	
STEP	SCORE
GETTING READY	
1. Explain to the woman and family your findings and what will happen during the delivery.	
2. Make sure everything is clean and ready for the birth.	
3. Gather equipment.	
4. Put on PPE.	
5. Perform hand hygiene and put on gloves.	
PROCEDURE	
6. Clean genital area with antiseptic solution or soap and water.	
7. Confirm full dilation of the cervix.	
8. Assist the woman into a good birthing position.	
9. Work with the woman to push and not to push to allow slow delivery of the baby.	
10. When the face appears at the vulva: <ul style="list-style-type: none"> The chin will present beneath the symphysis pubis bone with the head flexed. Protect the perineum to prevent laceration. When the chin is delivered, the head will flex to allow delivery of the occiput over the perineum. 	
11. Check for cord around the baby’s neck while encouraging the woman not to push.	
12. Wipe the baby’s face.	
13. Deliver baby’s shoulders and body: <ul style="list-style-type: none"> Cup hands parallel around the sides of the baby’s head. Do not hold the neck. Deliver anterior shoulder first and slowly move the baby’s head down toward the coccyx. Deliver posterior shoulder second and slowly move the baby’s head toward the woman’s abdomen. 	
14. Lay the baby on a cloth on the mother’s abdomen.	
15. Dry and warm the baby while looking for breathing.	
16. Remove the wet cloth. Place baby skin to skin on the mother’s abdomen.	
17. Cover the baby and mother with a dry cloth, making sure the baby’s head is covered.	
18. Feel the uterus to make sure there is no other baby.	

CHECKLIST FOR CONDUCTING DELIVERY OF FACE PRESENTATION (MENTO-ANTERIOR)	
STEP	SCORE
19. Give 10 units of oxytocin IM within 1 minute after the birth.	
20. Clamp and cut cord about 2–3 minutes after birth.	
21. Clamp and cut cord about 2–3 minutes after birth (delaying clamping increases baby's blood volume): <ul style="list-style-type: none"> • Clamp the cord approximately 3 cm from the baby's umbilicus. • With a second clamp, clamp the cord approximately 5 cm from the baby's umbilicus. • Cut between the 2 clamps. 	
22. Keep the mother and baby together.	
23. Do Apgar score at 1 and 5 minutes.	
24. Deliver the placenta: <ul style="list-style-type: none"> • Guard uterus (counter-traction to prevent uterine inversion). • Hold cord close to perineum. • With uterine contraction, gently pull cord with steady tension, following the birth canal curve. Be patient. • When you see the placenta, release cord and uterine pressure. • Deliver the placenta and membranes with both hands. • Massage the empty uterus until it is contracted. • Inspect placenta and membrane for completeness. 	
25. Cover the baby and mother with a dry cloth, making sure the baby's head is covered.	
26. Estimate blood loss. Look at all blood clots, blood-stained cloths for parts of placenta or membranes.	
27. Clean and check the woman for laceration and other problems.	
28. Perform hand hygiene.	
29. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO CONDUCT DELIVERY OF FACE PRESENTATION (MENTO-ANTERIOR)

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

CHECKLIST 14.3: THE MANAGEMENT OF WOMAN IN LABOR WITH BABY IN OCCIPUT POSTERIOR POSITION

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR THE MANAGEMENT OF WOMAN IN LABOR WITH BABY IN OCCIPUT POSTERIOR POSITION	
STEP	SCORE
GETTING READY	
1. Explain the procedure to the patient.	
2. Do a rapid assessment of the woman's general condition: <ul style="list-style-type: none"> Blood pressure Respiration Pulse Temperature 	
3. Assess the fetal condition: <ul style="list-style-type: none"> FHR: <100 or >180 is fetal distress. Membranes/Liquor: note the color. 	
PROCEDURE	
4. Provide encouragement and supportive care: <ul style="list-style-type: none"> Encourage support from chosen birth companion. Arrange seating for the companion next to the woman. Encourage the companion to give adequate support to the woman during labor and births (rub her back, wipe her face with a wet cloth, etc.). Suggest change of position. Encourage mobility. 	
5. Review progress of labor using the partograph.	
6. Observe the woman closely: <ul style="list-style-type: none"> If signs of obstruction, and fetal heart rate normal: <ul style="list-style-type: none"> Encourage the woman to walk around, or Change position to allow spontaneous rotation. If signs of obstruction, fetal heart rate abnormal (<100 or >180 per minute at any stage: <ul style="list-style-type: none"> Inform the doctor for C/S if in the hospital; refer if in clinic or health center. If membranes are intact: <ul style="list-style-type: none"> Rupture the membranes with an amniotic hook or Kocher clamp. If cervix not fully dilated and no signs of obstruction: <ul style="list-style-type: none"> Augment labor with oxytocin. If cervix is fully dilated, but no descent: 	

CHECKLIST FOR THE MANAGEMENT OF WOMAN IN LABOR WITH BABY IN OCCIPUT POSTERIOR POSITION	
STEP	SCORE
– Assess for signs of obstruction; if no signs, augment the labor with oxytocin.	
<ul style="list-style-type: none"> • If cervix is fully dilated and if: <ul style="list-style-type: none"> – The head is more than 3/5 above the symphysis pubis or the leading bony edge of the fetal head is above 2 station: • Inform the doctor for reassessment and C/S. <ul style="list-style-type: none"> – The fetal head is between 1/5 and 3/5 above the symphysis or the leading bony edge of the fetal head is between 0 station and 2 station: • Deliver by vacuum extraction; if failed, inform the doctor for C/S. <ul style="list-style-type: none"> – The fetal head is not more than 1/5 above the symphysis or the leading bony edge of the fetal head is 0 station: • Deliver by vacuum extraction. 	
<ul style="list-style-type: none"> • If cervix is fully dilated, but no descent: <ul style="list-style-type: none"> – - Assess for signs of obstruction; if no signs, augment the labor with oxytocin. 	
<ul style="list-style-type: none"> • If cervix is fully dilated and if: <ul style="list-style-type: none"> – The head is more than 3/5 above the symphysis pubis or the leading bony edge of the fetal head is above 2 station: <ul style="list-style-type: none"> ▪ Inform the doctor for reassessment and C/S. – The fetal head is between 1/5 and 3/5 above the symphysis or the leading bony edge of the fetal head is between 0 station and 2 station: <ul style="list-style-type: none"> ▪ Deliver by vacuum extraction; if failed, inform the doctor for C/S. – The fetal head is not more than 1/5 above the symphysis or the leading bony edge of the fetal head is 0 station: <ul style="list-style-type: none"> ▪ Deliver by vacuum extraction. 	
7. Perform hand hygiene.	
8. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ QUALIFIED ☐ NOT QUALIFIED TO PERFORM OCCIPUT DELIVERY

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

CHECKLIST 14.4: MONITORING LABOR PROGRESS USING THE PARTOGRAPH

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR MONITORING LABOR PROGRESS USING THE PARTOGRAPH	
STEP	SCORE
GETTING READY	
1. Welcome and greet the mother and family in a respectful way.	
2. Encourage and reassure the woman in labor and her family.	
3. Ask about her general well-being. (How are you? Where are you feeling the pain?)	
4. Start the labor record (partograph) by writing client information: <ul style="list-style-type: none"> • Name • Gravida and parity • Time membranes ruptured • Date and time of arrival 	
PROCEDURE	
5. Monitor progress of labor—Vaginal exam every 4 hours or as indicated: <ul style="list-style-type: none"> • Cervical dilatation • Cervical effacement • Position of head 	
6. Record time of admission at the bottom of the graph in the first square.	
7. Plot dilatation with “X”: <ul style="list-style-type: none"> • Latent phase 0 to 3 cm (maximum 8 hours) • Active phase 4 to 10 cm (average 1cm/hour) • Transfer from latent to active phase with broken line. 	
8. Record if progress is satisfactory (dilatation remains on or left of alert line).	
9. Descent of the fetal head (abdominal): <ul style="list-style-type: none"> • Latent phase every 4 hours • Active phase every hour and before vaginal exam • Place your hand on the abdomen over the baby’s head: <ul style="list-style-type: none"> – Measure if all 5 fingers can cover the head =5/5 – 4 fingers =4/5 – 3 fingers =3/5 – 2 fingers =2/5 – 1 fingers =1/5 	
10. Plot descent of the head with an “O”.	

CHECKLIST FOR MONITORING LABOR PROGRESS USING THE PARTOGRAPH	
STEP	SCORE
11. Interpret progress (satisfactory if fetal head descends).	
12. Uterine contractions: <ul style="list-style-type: none"> Latent phase: feel the length (duration) and count how many (frequency) in 10 minutes every hour. Active phase: feel the length (duration) and count how many (frequency) in 10 minutes every 30 minutes. 	
13. Plot contractions: <ul style="list-style-type: none"> Length (duration) of contractions: <ul style="list-style-type: none"> <20 seconds shade with dots 20–40 seconds shade with diagonal lines >40 seconds shade solid Frequency—shade one square for each contractions felt in 10 minutes. 	
14. Decide progress of labor (satisfactory if contractions become more frequent and last longer).	
15. Fetal condition: FHR: <ul style="list-style-type: none"> Listen and count every 30–60 minutes Listen/count every 15 minutes if: <ul style="list-style-type: none"> Meconium present No amniotic fluid seen with rupture of membranes Record the rate (FHR) at the top of partograph with “ ”. 	
16. Membranes and amniotic fluid (liquor): <ul style="list-style-type: none"> Look for liquor at each vagina exam. Record on the top just below the FHR: <ul style="list-style-type: none"> Clear liquor = “C” Bloody liquor = “B” Meconium-stained liquor = “M” Absent (no) liquor = “A” Intact membrane = “I” 	
17. Molding: <ul style="list-style-type: none"> Feel the sutures for molding at each vagina examination. Record on the partograph under liquor: <ul style="list-style-type: none"> Bones are separated, sutures can be felt “O” Bones are just touching = + Bones are overlapping but can be separated = ++ Bones are overlapping but cannot be separated = +++ 	
18. Interpret molding (0 is a sign that the baby will fit into the mother’s pelvis).	
19. Maternal condition: <ul style="list-style-type: none"> Pulse rate every 4 hours BP and temperature every 4 hours Urine: <ul style="list-style-type: none"> Check protein if signs of pre-eclampsia Volume (encourage passing urine every 2–4 hours) 	
20. Drugs and fluids: <ul style="list-style-type: none"> Oral fluids: Offer every hour Intravenous fluids as indicated Drugs as indicated 	
21. Record maternal condition information at the bottom of the partograph.	

CHECKLIST FOR MONITORING LABOR PROGRESS USING THE PARTOGRAPH	
STEP	SCORE
22. Record observations and action: <ul style="list-style-type: none"> Decide if in labor (start partograph). Decide if status normal or not normal. 	
Labor: <ul style="list-style-type: none"> Latent phase longer than 8 hours Active phase progress less than 1cm/hour No fetal descent 	
Baby: <ul style="list-style-type: none"> Meconium present Abnormal fetal heart rate Abnormal fetal lie or position Marked (++ or more) molding 	
Mother: <ul style="list-style-type: none"> Abnormal vital signs Protein in urine Urine less than 50 cc or dark yellow 	
23. Take action: Refer as needed using guidelines.	
24. Back of partograph: <ul style="list-style-type: none"> Top of the page: <ul style="list-style-type: none"> Record additional information about labor care. Write observations during labor. Write only information not recorded on the front of the partograph. 	
25. Bottom part of the back page: <ul style="list-style-type: none"> Record delivery information. Record third stage information. Record Apgar score and baby information. Record any complications. Sign name and date. 	
26. Perform hand hygiene.	
27. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO MONITOR LABOR USING THE PARTOGRAPH

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

14.4.1 EXERCISE: USING THE PARTOGRAPH

PURPOSE

The purpose of this exercise is to enable participants to practice using the partograph to manage labor.

INSTRUCTIONS

The trainer should review the partograph form with participants before beginning the exercise.

Each participant should be given three blank partograph forms.

Case 1: The trainer should read each step to the class, plot the information on the poster-size laminated partograph, and ask the questions included in each of the steps. At the same time, participants should plot the information on one of their partograph forms.

Case 2: The trainer should read each step to the class and have participants plot the information on another of their partograph forms. The questions included in each step should be asked as they arise.

Case 3: The trainer should read each step to the class and have participants plot the information on the third of their partograph forms. The questions should then be asked when the partograph is completed.

Throughout the exercise, the trainer should ensure that participants have completed their partograph forms correctly.

The trainer should provide participants with the three completed partograph forms from the Answer Key and have them compare these with the partograph forms they have completed. The trainer should discuss and resolve any differences between the partographs completed by participants and those in the Answer Key.

RESOURCES

The following equipment or representations thereof:

- 1) Partograph forms (three for each participant)
- 2) Poster-size laminated partograph

Exercise: Using the Partograph Answer Key

EXERCISE: USING THE PARTOGRAPH: CASE 1

STEP 1

- Mrs. A. was admitted at 05.00 on 12.5.2000
- Membranes ruptured 04.00
- Gravida 3, Para 2+0
- Hospital number 7886
- On admission the fetal head was 4/5 palpable above the symphysis pubis and the cervix was 2 cm dilated

Q: What should be recorded on the partograph?

Note: The woman is not in active labor. Record only the details of her history, i.e., first 4 bullets, not the descent and cervical dilatation.

STEP 2

- 09.00:
 - The fetal head is 3/5 palpable above the symphysis pubis
 - The cervix is 5 cm dilated

Q: What should you now record on the partograph?

Note: The woman is now in the active phase of labor. Plot this and the following information on the partograph:

- There are 3 contractions in 10 minutes, each lasting 20–40 seconds
- Fetal heart rate (FH) 120
- Membranes ruptured, amniotic fluid clear
- Sutures of the skull bones are apposed
- Blood pressure 120/70 mm Hg
- Temperature 36.8°C
- Pulse 80 per minute
- Urine output 200 mL; negative protein and acetone

Q: What steps should be taken?

Q: What advice should be given?

Q: What do you expect to find at 13.00?

STEP 3

Plot the following information on the partograph:

09.30 FH 120, Contractions 3/10 each 30 sec, Pulse 80
10.00 FH 136, Contractions 3/10 each 30 sec, Pulse 80
10.30 FH 140, Contractions 3/10 each 35 sec, Pulse 88
11.00 FH 130, Contractions 3/10 each 40 sec, Pulse 88, Temp 37
11.30 FH 136, Contractions 4/10 each 40 sec, Pulse 84, Head is 2/5 up
12.00 FH 140, Contractions 4/10 each 40 sec, Pulse 88
12.30 FH 130, Contractions 4/10 each 45 sec, Pulse 88
13.00 FH 140, Contractions 4/10 each 45 sec, Pulse 90, Temp 37

- 13.00:
 - The fetal head is 0/5 palpable above the symphysis pubis
 - The cervix is fully dilated
 - Amniotic fluid clear
 - Sutures apposed
 - Blood pressure 100/70 mm Hg
 - Urine output 150 mL; negative protein and acetone

Q: What steps should be taken?

Q: What advice should be given?

Q: What do you expect to happen next?

STEP 4

Record the following information on the partograph:

- 13.20: Spontaneous delivery of a live female infant, Wt. 2.850 g

Answer the following questions:

Q: How long was the active phase of the first stage of labor?

Q: How long was the second stage of labor?

EXERCISE: USING THE PARTOGRAPH: CASE 2

STEP 1

- Mrs. B. was admitted at 10.00 on 2.5.2000
- Membranes intact
- Gravida 1, Para 0+0
- Hospital number 1443

Record the information above on the partograph, together with the following details:

- The fetal head is 5/5 palpable above the symphysis pubis
- The cervix is 4 cm dilated
- There are 2 contractions in 10 minutes, each lasting less than 20 seconds
- FH 140
- Membranes intact
- Blood pressure 100/70 mm Hg
- Temperature 36.2°C
- Pulse 80 per minute
- Urine output 400 mL; negative protein and acetone

Q: What is your diagnosis?

Q: What action will you take?

STEP 2

Plot the following information on the partograph:

10.30 FH 140, Contractions 2/10 each 15 sec, Pulse 90

11.00 FH 136, Contractions 2/10 each 15 sec, Pulse 88, Membranes intact

11.30 FH 140, Contractions 2/10 each 20 sec, Pulse 84

12.00 FH 136, Contractions 2/10 each 15 sec, Pulse 88, Temp 36.2

- The fetal head is 5/5 palpable above the symphysis pubis
- The cervix is 4 cm dilated, membranes intact

Q: What is your diagnosis?

Q: What action will you take?

STEP 3

Plot the following information on the partograph:

12.30 FH 136, Contractions 1/10 each 15 sec, Pulse 90

13.00 FH 140, Contractions 1/10 each 15 sec, Pulse 88

13.30 FH 130, Contractions 1/10 each 20 sec, Pulse 88

14.00 FH 140, Contractions 2/10 each 20 sec, Pulse 90, Temp 36.8, Blood pressure 100/70

- The fetal head is 5/5 palpable above the symphysis pubis
- Urine output 300 mL; negative protein and acetone
- Membranes intact

Q: What is your diagnosis?

Q: What will you do?

Plot the following information on the partograph:

- The cervix is 4 cm dilated, sutures apposed
- Labor augmented with oxytocin 2.5 units in 500 mL IV fluid at 10 drops per minute (dpm)

STEP 4

Plot the following information on the partograph:

- 14.30:
 - 2 contractions in 10 minutes each lasting 30 seconds
 - Infusion rate increased to 20 dpm
 - FH 140, Pulse 88
- 15.00:
 - 3 contractions in 10 minutes each lasting 30 seconds
 - Infusion rate increased to 30 dpm
 - FH 140, Pulse 90
- 15.30:
 - 3 contractions in 10 minutes each lasting 30 seconds
 - Infusion rate increased to 40 dpm
 - FH 140, Pulse 88
- 16.00:
 - The fetal head is 2/5 palpable above the symphysis pubis
 - The cervix is 6 cm dilated; sutures apposed
 - 3 contractions in 10 minutes each lasting 30 seconds
 - Infusion rate increased to 50 dpm
 - FH 144, Pulse 92
- 16.30:
 - FH 140, Contractions 3/10 each 45 sec, Pulse 90

Q: What steps would you take?

STEP 5

17.00 FH 138, Pulse 92, Contractions 3/10 each 40 sec, Maintain at 50 dpm
17.30 FH 140, Pulse 94, Contractions 3/10 each 45 sec, Maintain at 50 dpm
18.00 FH 140, Pulse 96, Contractions 4/10 each 50 sec, Maintain at 50 dpm
18.30 FH 144, Pulse 94, Contractions 4/10 each 50 sec, Maintain at 50 dpm

STEP 6

Plot the following information on the partograph:

- 19.00:
 - The fetal head is 0/5 palpable above the symphysis pubis
 - FH 144, Contractions 4/10 each 50 sec, Pulse 90
 - The cervix is fully dilated

STEP 7

Record the following information on the partograph:

- 19.30:
 - FH 142, Contractions 4/10 each 50 sec, Pulse 100
- 20.00:
 - FH 146, Contractions 4/10 each 50 sec, Pulse 110
- 20.10:
 - Spontaneous delivery of a live male infant, Wt. 2.654 g

Answer the following questions:

Q: How long was the active phase of the first stage of labor?

Q: How long was the second stage of labor?

Q: Why was labor augmented?

EXERCISE: USING THE PARTOGRAPH: CASE 3**STEP 1**

- Mrs. C. was admitted at 10.00 on 12.5.2000
- Membranes ruptured 09.00
- Gravida 4, Para 3+0
- Hospital number 6639

Record the information above on the partograph, together with the following details:

- The fetal head is 3/5 palpable above the symphysis pubis
- The cervix is 4 cm dilated
- There are 3 contractions in 10 minutes, each lasting 30 seconds
- FH 140
- Amniotic fluid clear
- Sutures apposed
- Blood pressure 120/70 mm Hg
- Temperature 36.8°C
- Pulse 80 per minute
- Urine output 200 mL; negative protein and acetone

STEP 2

Plot the following information in the partograph:

10.30 FH 130, Contractions 3/10 each 35 sec, Pulse 80
11.00 FH 136, Contractions 3/10 each 40 sec, Pulse 90
11.30 FH 140, Contractions 3/10 each 40 sec, Pulse 88
12.00 FH 140, Contractions 3/10 each 40 sec, Pulse 90, Temp 37, Head 3/5 up
12.30 FH 130, Contractions 3/10 each 40 sec, Pulse 90
13.00 FH 130, Contractions 3/10 each 40 sec, Pulse 88
13.30 FH 120, Contractions 3/10 each 40 sec, Pulse 88
14.00 FH 130, Contractions 4/10 each 45 sec, Pulse 90, Temp 37, Blood pressure 100/70

- The fetal head is 3/5 palpable above the symphysis pubis
- The cervix is 6 cm dilated, amniotic fluid clear
- Sutures overlapped but reducible

STEP 3

14.30 FH 120, Contractions 4/10 each 40 sec, Pulse 90, Liquor clear
15.00 FH 120, Contractions 4/10 each 40 sec, Pulse 88, Blood stained
15.30 FH 100, Contractions 4/10 each 45 sec, Pulse 100
16.00 FH 90, Contractions 4/10 each 50 sec, Pulse 100, Temp 37
16.30 FH 90, Contractions 4/10 each 50 sec, Pulse 110, Head 3/5 up, Meconium liquor

- The fetal head is 3/5 palpable above the symphysis pubis
- The cervix is 6 cm dilated
- Amniotic fluid meconium stained
- Sutures overlapped and not reducible
- Urine output 100 mL; protein negative, acetone 1+

STEP 4

Record the following information on the partograph:

- Cesarean section at 17.00, live female infant with poor respiratory effort, Wt. 4,850 g

Answer the following questions:

Q: What is the final diagnosis?

Q: What action was indicated at 14.00, and why?

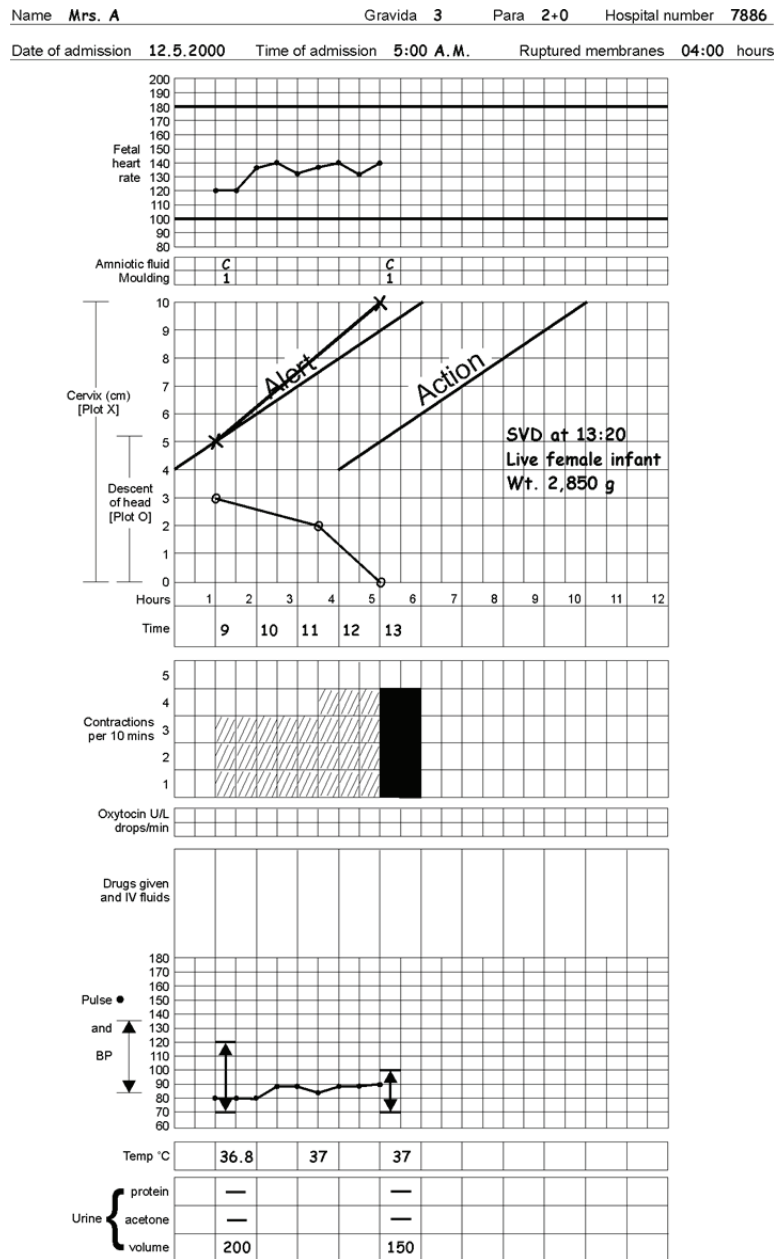
Q: What action was indicated at 16.00, and why?

Q: At 16.30, a decision was taken to do a cesarean section, and this was Put one. Was this a correct action?

Q: What problems may be expected in the newborn?

14.4.2 EXERCISE: USING THE PARTOGRAPH ANSWER KEY

CASE 1



STEP 1—see partograph

STEP 2—see partograph

- Steps: Inform of findings and what to expect; encourage to ask questions; provide comfort measures, hydration, nutrition.
- Advice: Assume position of choice; drink plenty of fluids; eat as desired.
- Expect at 13.00: Progress to at least 9 cm dilatation.

STEP 3

- Steps: Prepare for birth.
- Advice: Push only when urge to push.
- Expect: Spontaneous vaginal delivery.

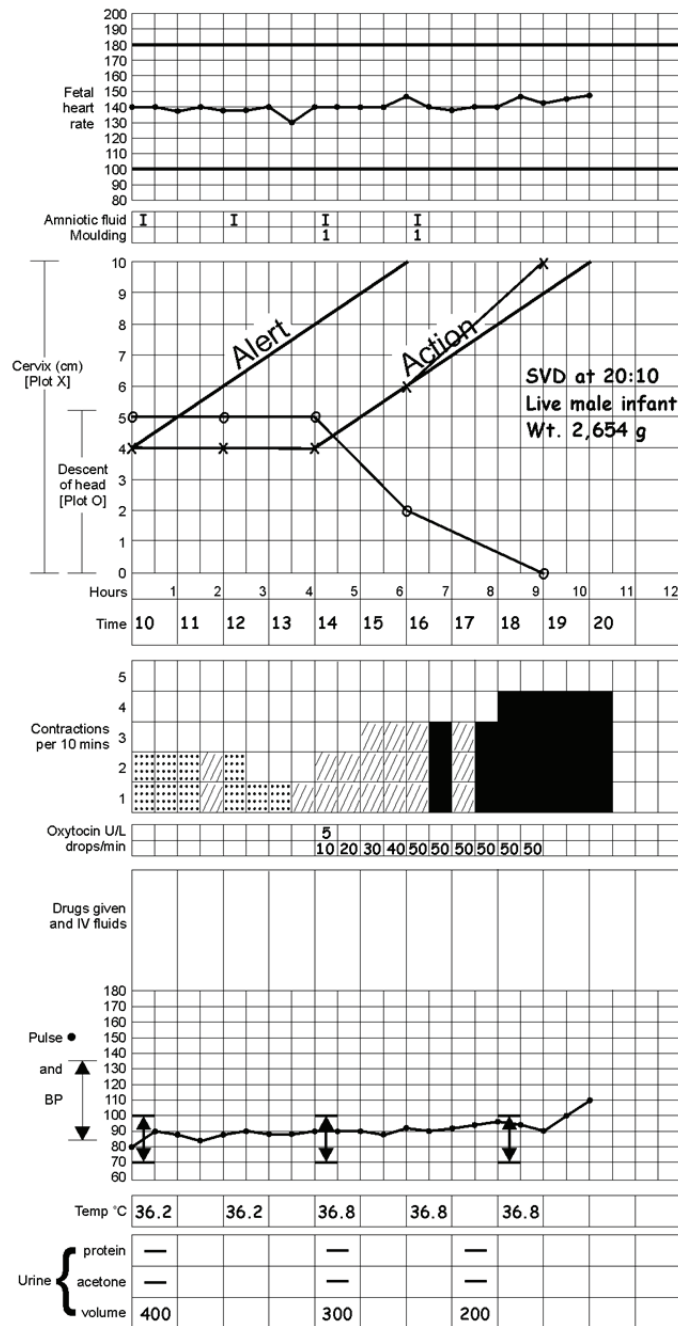
STEP 4

- 1st stage of active labor: 4 hrs
- 2nd stage of active labor: 20 min

CASE 2

Name **Mrs. B** Gravida **1** Para **0+0** Hospital number **1443**

Date of admission **2.5.2000** Time of admission **10:00 A.M.** Ruptured membranes **14:00** hours



STEP 1

- Diagnosis: Active labor
- Action: Inform Mrs. B. and family about findings and what to expect; give continual opportunity to ask questions; encourage ambulation and to drink and eat as wanted.

STEP 2

- Diagnosis: Prolonged active phase (cervical dilatation plotted to the right of the alert line on the partograph).
- Action: The facilitator should take the opportunity to open a discussion about using oxytocin

for augmenting labor based on the clinical setting. For instance, is the woman being cared for at a health post that is 4 hours away from a district hospital where an oxytocin drip can be started? Or if she is being cared for in a district hospital, can other measures be used (such as hydration, ambulation) before oxytocin is started?

STEP 3

- Diagnosis: Prolonged active phase; less than 3 contractions per 10 min lasting greater than 40 sec; good maternal and fetal condition.
- Action: Augment labor with oxytocin and artificial rupture of membranes; inform of findings and what to expect; reassure; answer questions; encourage drink and assume position of choice.

STEP 4

- Steps: Continue to augment, provide comfort (psychological and physical); encourage drink and nutrition.

STEP 5—see partograph

STEP 6—see partograph

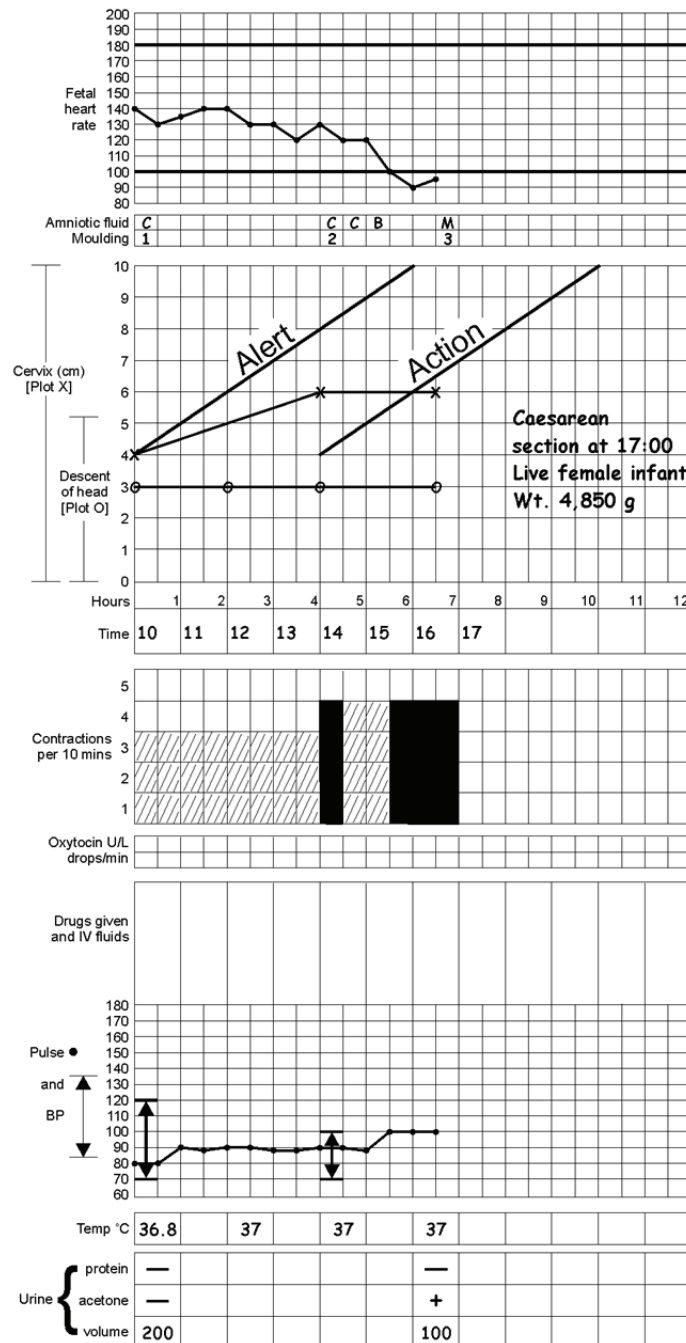
STEP 7

- 1st stage of active labor: 9 hrs
- 2nd stage of active labor: 1 hr 10 min
- Why augment: Less than 3 contractions per 10 min lasting greater than 40 sec (lack of progress).

CASE 3

Name **Mrs. C** Gravida **4** Para **3+0** Hospital number **6639**

Date of admission **12.5.2000** Time of admission **10:00 A.M.** Ruptured membranes **09:00** hours



STEP 1—see partograph

STEP 2—see partograph

STEP 3—see partograph

STEP 4—see partograph

- Final diagnosis: Obstructed labor
- Action at 14.00: Continue emotional and physical support, including hydration; continue attentive monitoring of maternal and fetal condition. Why? Woman and family may become

discouraged with lack of progress and emotionally and physically exhausted; have crossed alert line.

- Perform cesarean section because the patient is already in secondary arrest of dilatation and descent despite at least 3 contractions per 10 minutes lasting greater than 40 seconds.
- Yes, was correct action because fetal condition was deteriorating, lack of progress despite at least 3 contractions per 10 minutes lasting greater than 40 seconds, acetone in urine, rising maternal pulse. However, action was delayed longer than was best for mother and baby.
- Problems expected in newborn—asphyxia, meconium aspiration.

CHECKLIST 14.5: NORMAL DELIVERY AND ACTIVE MANAGEMENT OF THIRD STAGE OF LABOR

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR NORMAL DELIVERY AND ACTIVE MANAGEMENT OF THIRD STAGE OF LABOR	
STEP	SCORE
GETTING READY	
1. Greet the patient and relatives respectfully.	
2. Verify the patient's identity.	
3. Explain to the woman or relatives her present condition; answer questions.	
4. Assemble all needed materials on a tray and place it at the bedside.	
5. Ensure that the bladder is empty.	
6. Place the woman in a comfortable birthing position.	
7. Perform hand hygiene and put on gloves.	
PROCEDURE	
8. Swab the vulva.	
9. Work with the woman to push and not push, to allow for slow delivery of the baby.	
10. Protect the perineum.	
11. Check for cord around the neck while encouraging the woman not to push.	
12. Wipe the baby's face.	
13. Perform delivery of the baby's shoulder.	
14. Cup hands parallel around the sides of the baby's head.	
15. Deliver anterior shoulder first by slowly moving the baby's head towards the woman's coccyx.	
16. Deliver posterior shoulder second by slowly moving the baby's head toward the woman's legs.	
17. Dry and warm the baby with a dry cloth, making sure the baby's head is covered.	
18. Lay the baby on a cloth on the mother's abdomen to promote breastfeeding, or on the delivery table/bed between the woman's legs.	
19. Remove the wet cloth and cover the baby with a dry cloth, making sure the baby's head is covered.	
20. Feel the uterus to make sure there is no other baby (AMTSL).	
21. Give 10 units oxytocin IM within 1 minute after the birth, if no other baby.	

CHECKLIST FOR NORMAL DELIVERY AND ACTIVE MANAGEMENT OF THIRD STAGE OF LABOR	
STEP	SCORE
22. Clamp and cut the cord 2–3 minutes after birth (delaying clamping increases baby's blood volume).	
23. First, clamp toward the baby.	
24. Second, clamp toward the placenta.	
25. Cut the cord between the two clamps.	
26. Do Apgar score at 1 and 5 minutes after birth.	
27. Tie the cord 2 fingers breadth above the umbilical stump.	
DELIVERY OF PLACENTA	
28. Guard the uterus to prevent uterine inversion.	
29. Hold cord close to perineum.	
30. With uterine contractions, gently pull cord with steady tension, following birth canal curve. Be patient.	
31. When you see the placenta, release cord and uterine pressure.	
32. Deliver the placenta and membrane with both hands.	
33. Rub the empty uterus until it is contracted.	
34. Inspect placenta and membrane for completeness.	
35. Estimate blood loss. Look at all blood clots, blood-stained cloths for parts of placenta or membranes.	
36. Put all used instruments in 0.5% chlorine solution.	
37. Check and clean the woman for tears and other problems.	
38. Perform hand hygiene.	
39. Transfer mother and baby to postpartum ward, encourage initial breastfeeding, and keep mother and baby together.	
40. Explain your findings to the woman.	
41. Entertain questions from the woman.	
42. Properly discard of all used materials.	
43. Properly remove and dispose of gloves, if any.	
44. Perform hand hygiene.	
45. Document procedure and/or findings: V/S IV infusion, condition of placenta and membranes, estimated blood loss, and amount of oxytocin.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM NORMAL DELIVERY AND AMTSL

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

CHECKLIST 14.6: TWIN DELIVERY

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR TWIN DELIVERY	
STEP	SCORE
GETTING READY	
1. Wash equipment, instruments, delivery furniture, or floor (if no assistant available).	
2. Put on PPE.	
3. Change shoes in delivery area.	
4. Perform hand hygiene.	
5. Keep hands above elbows.	
6. Start an IV line or infusion for the mother and slowly infuse fluids.	
7. Monitor fetal heart tone or rate, if one rate is less than 100 or more than 180 b/m, suspect fetal distress (thick meconium-stained amniotic fluid).	
8. Check presentation, if vertex presentation allows labor to progress as for a single vertex presentation (monitor progress of labor using a partograph).	
9. Determine whether there is a breech presentation.	
10. Leave a clamp on the maternal end of the umbilical cord and do not attempt to deliver the placenta until the 2nd baby is delivered.	
11. (2nd Baby) Immediately after the first baby is delivered, palpate the abdomen to determine the lie of the other baby.	
12. Correct to longitudinal lie by external version. Check fetal heart rates.	
13. Perform a vaginal examination to determine if the cord has prolapsed.	
14. Check whether the membranes are intact or ruptured.	
15. Check presentation of other babies.	
16. Perform hand hygiene.	
17. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO CONDUCT TWIN DELIVERY

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 15: ENEMA ADMINISTRATION

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR ENEMA ADMINISTRATION	
STEP	SCORE
GETTING READY	
1. Verify order: Check the patient’s chart for physician’s order.	
2. Assemble all needed materials on a bedside table.	
3. Greet the patient and relative, verifying the patient’s identity.	
4. Perform hand hygiene.	
5. Clearly explain to the patient or relatives the purpose of the enema.	
6. Explain that he/she may feel pressure.	
7. Assist the adult client to a left lateral position, with the right leg as acutely flexed as possible.	
PROCEDURE	
8. Drape the patient with a blanket, leaving only buttocks and rectum exposed.	
9. Put on clean procedure gloves.	
10. Open the prepackaged enema. Remove the plastic cap from the container. The tip of the prepackaged enema container comes pre-lubricated. Add extra lubricant as needed.	
11. Lift the upper buttock to ensure good visualization of the anus.	
12. Insert the tube smoothly and slowly into the rectum, directing it toward the umbilicus, 7–10cm, asking the patient to take slow, deep breaths.	
13. If tube does not insert with ease, do not force; remove, re-lubricate, and retry.	
14. Slowly administer the enema solution.	
15. Raise the solution container no higher than 30 cm and open the clamp to allow fluid flow.	
16. Ask the patient to hold fluid for 10 minutes.	
17. Remove gloves and perform hand hygiene.	
18. Give the patient the call light or ask relative to call for assistance.	
19. Assist the patient onto bedpan to release fluid and intestinal contents.	
20. Perform hand hygiene.	
21. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ QUALIFIED ☐ NOT QUALIFIED TO PERFORM ENEMA ADMINISTRATION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 16: EPISIOTOMY REPAIR

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR EPISIOTOMY AND REPAIR						
STEP	CASES					
GETTING READY						
1. Prepare the necessary equipment.						
2. Tell the woman (and her support person) what is going to be done and encourage them to ask questions.						
3. Provide continual emotional support and reassurance, as feasible.						
4. Ask about allergies to antiseptics and anesthetics.						
5. Perform hand hygiene and put on personal protective barriers.						
MAKING THE EPISIOTOMY						
6. Clean the perineum with antiseptic solution.						
7. Administer local anesthetic.						
8. Perform episiotomy when perineum is thinned out and the baby's head is visible during a contraction.						
9. Insert 2 fingers into the vagina between the baby's head and the perineum.						
10. Insert the open blade of the scissors between the perineum and the fingers. Make a single cut in a mediolateral direction.						
11. If delivery of the head does not follow immediately, apply pressure to the episiotomy site between contractions.						
12. Control delivery of the head to avoid extension of the episiotomy.						
REPAIRING THE EPISIOTOMY						
13. Clean the woman's perineum with antiseptic solution.						
14. Repeat local anesthetic, if necessary.						
15. Use a continuous suture from the apex downward to repair the vaginal incision.						
16. At the vaginal opening, bring the cut edges together.						
17. Bring the needle under the vaginal opening and out through the incision and tie.						
18. Use interrupted sutures to repair the perineal muscle, working from the top of the perineal incision downward and to bring the skin edges together.						
19. Place a clean pad on the woman's perineum.						

CHECKLIST FOR EPISIOTOMY AND REPAIR						
STEP	CASES					
POSTPROCEDURE TASKS						
20. Before removing gloves, dispose of waste materials in a leak-proof container or plastic bag.						
21. Place all instruments in 0.5% chlorine solution for decontamination.						
22. If reusing needle or syringe, fill syringe (with needle attached) with 0.5% chlorine solution and submerge in solution for decontamination. If disposing of needle and syringe, place in puncture-proof container.						
23. Remove gloves and discard them in a leak-proof container or plastic bag if disposing of or decontaminate them in 0.5% chlorine solution if reusing.						
24. Perform hand hygiene.						
25. Document procedure and/or findings.						
TOTAL						

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM EPISIOTOMY REPAIR

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 17: FAMILY PLANNING COUNSELING

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR FAMILY PLANNING COUNSELING	
STEP	SCORE
GETTING READY	
1. Ensure room is well-lit and ventilated.	
2. Ensure availability of chairs and table.	
3. Prepare equipment and supplies.	
4. Ensure availability of writing materials (e.g., client, daily activity register, follow-up cards).	
5. Ensure privacy.	
PROCEDURE	
6. Greet the woman respectfully.	
7. Confirm the woman's name, address, and other required information.	
8. Offer the woman a comfortable place to sit.	
9. Reassure the woman that the information in the counseling session is confidential.	
10. Ask the woman what she knows about family planning and if she has ever used a contraceptive method before; if yes: <ul style="list-style-type: none"> What methods did she use? Did she have any problems with that method or does she have any questions or concerns about that method? 	
11. Ask the woman about her reproductive goals.	
12. Give a brief description of the family planning methods available.	
13. Use body language to show interest in and concern for the woman.	
14. Ask questions appropriately and with respect. Elicits more than “yes” and “no” answers.	
15. Use language that the woman can understand.	
16. Appropriately use visual aids, such as posters, flipcharts, drawings, samples of methods and anatomic models.	
17. Assesses the woman's risk for STIs and HIV/AIDS, as appropriate.	

CHECKLIST FOR FAMILY PLANNING COUNSELING	
STEP	SCORE
18. Briefly provide general information about each contraceptive method available: <ul style="list-style-type: none"> • How it prevents pregnancy • How it is administered • Effectiveness • Advantages and disadvantages • Side effects • Need for protection against STIs including HIV/AIDS 	
19. Clarify any misinformation the woman may have about family planning methods.	
20. Ask which method interests the woman. Helps the woman chose a method.	
METHOD-SPECIFIC COUNSELING – Once the woman has chosen a method	
21. Using the language the woman will understand, take a reproductive and basic medical history.	
22. Perform a physical assessment that is appropriate for the method chosen; if indicated, refer the woman for evaluation.	
23. Ensure there are no conditions that contraindicate the use of the chosen method. If necessary, help the woman to find a more suitable method.	
24. Briefly, giving only the most important information, tell the woman about the family planning method she has chosen: Type, how it works, effectiveness, advantages and non-contraceptive benefits, disadvantages, contraindications, common side effects, and protection against STIs and HIV/AIDS.	
25. Provide the method of choice if available or refer woman to the nearest health facility where it is available.	
26. Give the woman instructions about her chosen methods of contraception : <ul style="list-style-type: none"> • How to use the method of contraception • Side effects • Tell her to return to the clinic if she has any problems • Any other relevant information 	
27. Educate the woman about prevention of STIs and HIV/AIDS, if she is at risk. If necessary, provide her with condoms, instructions on how to use them, and where to obtain them.	
28. Encourage the woman to repeat the instructions to be sure she understands.	
29. Ask if the woman has any questions or concerns. Listen attentively, and address her questions and concerns.	
30. Schedule the follow-up visit. Encourage the woman to return to the clinic at any time if necessary.	
31. Thank the woman, politely say goodbye, and encourage her to return to the clinic if she has any questions or concerns.	
32. Perform hand hygiene.	
33. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ QUALIFIED ☐ NOT QUALIFIED TO CONDUCT FAMILY PLANNING COUNSELING

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

17.1: ASSESS PREGNANCIES—HOW TO BE REASONABLY SURE A CLIENT IS NOT PREGNANT

How to Be Reasonably Sure a Client is Not Pregnant

Before initiating a medical regimen, health care providers often need to assess whether a woman is pregnant because some medications may have side effects that are potentially harmful to the fetus. According to the World Health Organization (WHO), there is no known harm to the woman, the course of her pregnancy, or fetus if COCs, DMPA (or NET-EN), CICs, the contraceptive patch, or ring are accidentally used during pregnancy. However, it is recommended that family planning providers assess whether a woman seeking contraceptive services might already be pregnant, because women who are currently pregnant do not require contraception. In addition, methods such as IUDs should never be initiated in pregnant women because doing so might lead to septic miscarriage, a serious complication. Although pregnancy can be reliably determined with pregnancy tests, in many areas, such tests are either not available or affordable for clients. In such cases, many clients who are not menstruating at the time of their visit are denied contraception, as providers rely on the presence of menses as an indicator that a woman is not pregnant. These women are often required to wait for their menses to return before they initiate a contraceptive method.

Other approaches can be used to rule out pregnancy in the absence of menses or laboratory tests. Family Health International (FHI), with support from the U.S. Agency for International Development (USAID), developed a simple checklist for use by family planning providers to help nonmenstruating clients safely initiate their method of choice. The checklist is based on criteria endorsed by the WHO to determine with reasonable certainty that a woman is not pregnant. Evaluation of the checklist in family planning clinics has demonstrated that the tool is very effective in correctly identifying women who are not pregnant. Furthermore, recent studies in Guatemala, Mali, and Senegal have shown that use of these checklists by family planning providers significantly reduced the proportion of clients being turned away due to menstrual status, and improved women's access to contraceptive services.

Although the original checklist was developed for use by family planning providers, it can be used by other health care providers who need to determine whether a client is pregnant. For example, pharmacists may use this checklist when prescribing certain medications that should be avoided during pregnancy (e.g., certain antibiotics or certain drugs that prevent seizures).

This checklist is part of a series of provider checklists for reproductive health services. The other checklists include the *Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN)*, the *Checklist for Screening Clients Who Want to Initiate Combined Oral Contraceptives (COCs)*, the *Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD*, and the *Checklist for Screening Clients Who Want to Initiate Contraceptive Implants*. For more information about the provider checklists, please visit www.fhi.org.

Explanation of the Questions

The checklist consists of six questions that providers ask clients while taking their medical history. If the client answers “yes” to any of these questions, and there are no signs or symptoms of pregnancy, then a provider can be reasonably sure that the woman is not pregnant.

Women who are in the first seven days of their menstrual cycle, who have had a miscarriage/abortion in the past seven days, or who are in their first four weeks postpartum, are protected from unplanned pregnancy because the possibility of ovulation in each of these situations is extremely low. With the IUD, the possibility of pregnancy is very low before day 12 of the menstrual cycle because of the additional contraceptive effectiveness of the copper IUD. Women who satisfy the lactational amenorrhea method criteria (e.g., women who are in their first six months postpartum, are fully or nearly-fully breastfeeding, and are amenorrheic) are protected from unplanned pregnancy because of the effects of lactational amenorrhea on the

reproductive cycle. Likewise, women who consistently and correctly use a reliable contraceptive method are effectively protected from pregnancy, as are those who have abstained from sexual intercourse since their last menstrual period.

Sources:

- ¹ Technical Guidance/Competence Working Group (TG/CWG). *Recommendations for Updating Selected Practices in Contraceptive Use: Volume II*. Washington: U.S. Agency for International Development, 1997.
- ² Stanback J, Qureshi Z, Nutley T, Sekadde-Kigundu C. Checklist for ruling out pregnancy among family-planning clients in primary care. *Lancet* 1999;354(August 14):566.
- ³ Stanback, John, Diabate Fatimata, Dieng Thierno, Duarter de Morales, Cummings Stirling, and Traore Mahamadou. Ruling Out Pregnancy Among Family Planning Clients: The Impact of a Checklist in Three Countries. *Studies in Family Planning* 2005;36[4]:311–315.

How to be Reasonably Sure a Client is Not Pregnant

Ask the client questions 1–6. As soon as the client answers **YES** to *any question*, stop, and follow the instructions.

NO	1. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	YES
NO	2. Have you abstained from sexual intercourse since your last menstrual period or delivery?	YES
NO	3. Have you had a baby in the last 4 weeks?	YES
NO	4. Did your last menstrual period start within the past 7 days (or within the past 12 days if you are planning to use an IUD)?	YES
NO	5. Have you had a miscarriage or abortion in the past 7 days (or within the past 12 days if you are planning to use an IUD)?	YES
NO	6. Have you been using a reliable contraceptive method consistently and correctly?	YES

If the client answered **NO** to *all of the questions*, pregnancy cannot be ruled out. The client should await menses or use a pregnancy test.

If the client answered **YES** to *at least one of the questions* and she is free of signs or symptoms of pregnancy, provide client with desired method.



CHECKLIST 17.2: ASSESSMENT AND COUNSELING FOR COMBINED ORAL CONTRACEPTIVE USE

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR ASSESSMENT AND COUNSELING FOR COMBINED ORAL CONTRACEPTIVE USE	
STEP	SCORE
GETTING READY	
1. Prepare the necessary equipment.	
2. Greet the woman, by name, with respect and kindness. Introduce yourself.	
3. Offer the woman a place to sit.	
4. Ensure confidentiality.	
5. Tell the woman what is going to be done and encourage her to ask questions. Listen to what the woman has to say.	
ASSESSMENT (Ask/Check Record)	
6. Ask the woman about her reproductive goals and need for contraception.	
7. Take a reproductive and basic medical history of the woman.	
8. Assess the woman’s risk for STIs and HIV/AIDS.	
9. Assess the woman’s blood pressure and take appropriate action.	
10. Ask the woman what she knows about the pill (combined oral contraceptives) and correct any misinformation.	
11. Briefly, giving only the most important information, tell the woman about the pill.	
12. Instruct the woman about how to take the pill.	
13. Have the woman repeat the instructions.	
14. Ask the woman if she has any questions. Answer any questions she has.	
15. Confirm eligibility.	
16. Provide the woman with the pill.	
17. Discuss return visits and follow-up with the woman; review side effects and warning signs. Schedule a follow-up visit in 3 months to make sure that the woman is not having any problems with the pill.	
18. Perform hand hygiene.	
19. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO CONDUCT ASSESSMENT AND FAMILY
PLANNING COUNSELING FOR COMBINED ORAL CONTRACEPTIVE USE

Assessor's Signature _____ Date _____

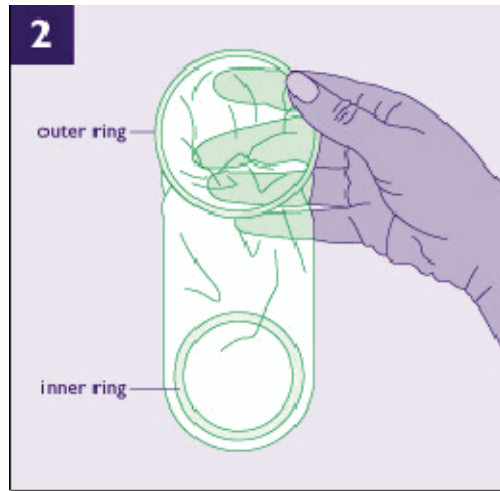
Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 17.3: HOW TO USE FEMALE CONDOMS



Open the female condom package carefully; tear at the notch on the top right of the package. Do not use scissors or a knife to open.



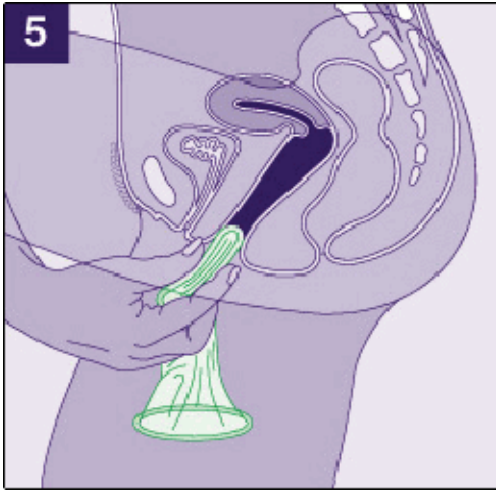
The outer ring covers the area around the opening of the vagina. The inner ring is used for insertion and to help hold the sheath in place during intercourse.



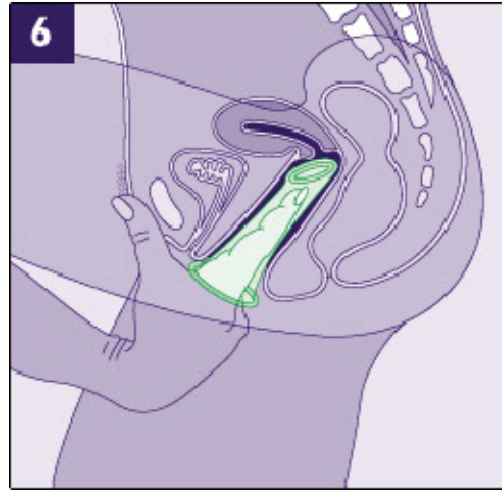
While holding the female condom at the closed end, grasp the flexible inner ring and squeeze it with the thumb and second or middle finger so it becomes long and narrow.



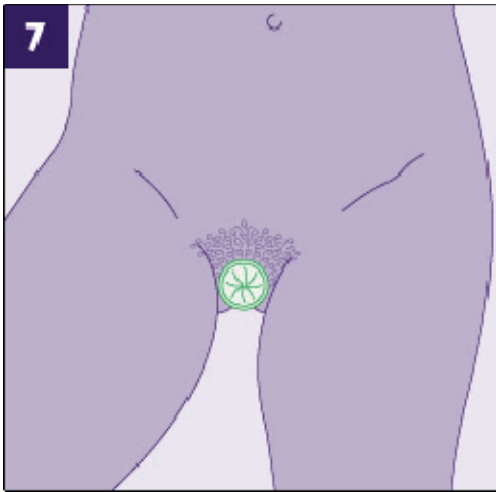
Choose a position that is comfortable for insertion – squat, raise one leg, sit, or lie down.



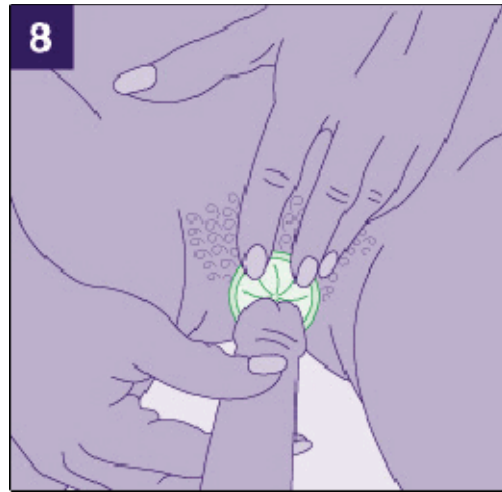
5
Gently insert the inner ring into the vagina. Feel the inner ring go up and move into place.



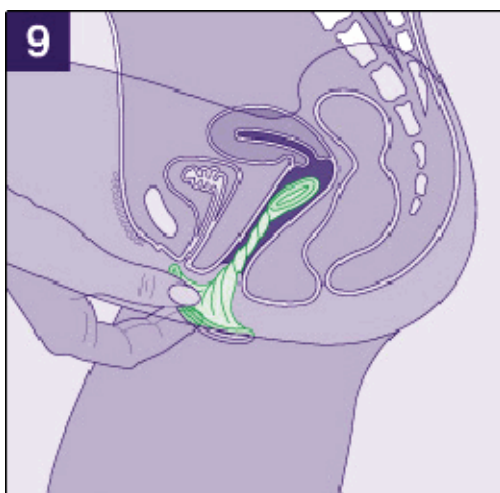
6
Place the index finger on the inside of the condom, and push the inner ring up as far as it will go. Be sure the sheath is not twisted. The outer ring should remain on the outside of the vagina.



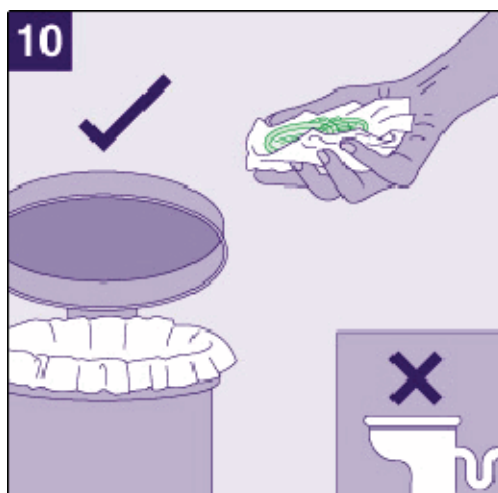
7
The female condom is now in place and ready for use with your partner.



8
When you are ready, gently guide your partner's penis into the condom's opening with your hand to make sure that it enters properly – be sure that the penis is not entering on the side, between the sheath and the vaginal wall.



To remove the female condom, twist the outer ring and gently pull the condom out.



Wrap the condom in the package or in tissue, and throw it in the garbage. Do not put it into the toilet.

FREQUENTLY ASKED QUESTIONS (FAQS) ABOUT THE FEMALE CONDOM

1. Is the female condom (FC) difficult to use?

The FC is not difficult to use, but it may take some practice to get used to it. Women should practice putting it in and removing it prior to using it for the first time during sexual intercourse. Research has indicated that female condoms may need to be tried up to three times before users become confident and comfortable using them. New users should try to insert the device several times, and each time with the body in a different position (e.g., lying down, crouching, sitting) to find the most comfortable one. While individual counseling and personal fitting may help to reassure women, group sessions and peer groups may overcome early abandonment as women can share anxieties, ideas, and laughter with each other.

2. What happens if the penis doesn't enter correctly?

It is important that the penis is guided into the center of the FC and not between the vaginal wall and the outer side of the FC. Diagrams and/or anatomical models should be used to illustrate this problem at introduction. If the penis does enter incorrectly, the man should withdraw his penis and the couple should start over.

3. What kind of lubricant should be used with the FC?

The FC comes pre-lubricated with a silicone-based, non-spermicidal lubricant. This lubrication helps assist in the insertion of the device and allows easy movement during intercourse. The lubricant may make female condoms a little slippery at first. If the outer ring of the FC gets pushed in or pulled out of the vagina, more lubricant may be needed. Also, if the FC makes noise during sex, simply add more lubricant. The FC can be used with both water-based and oil-based lubricants, whereas male latex condoms should only be used with water-based lubricants. Women, if you suffer from vaginal dryness, additional lubricant may be required.

4. Can the FC be used more than once?

The female condom is approved for a single use only, but re-use has been reported in several countries. WHO, UNAIDS, and USAID, among others, have conducted studies to investigate the safety of disinfection, washing, drying, storage, and re-lubrication, followed by re-use, and WHO has convened two technical consultations to review data from these studies.

WHO recommends use of a new male or female condom for every act of intercourse, where there is a risk of unintended pregnancy and/or STI/HIV infection. Recognizing the urgent need for risk-reduction strategies for women who cannot or do not access new condoms, WHO has developed a draft protocol for the safe handling and preparation of used female condoms intended for re-use. WHO does not recommend or promote re-use, but will make available the protocol, together with guidelines on programmatic issues, to program managers who intend to evaluate its feasibility and application in local settings. WHO's Information Update on re-use is available online at www.who.int/reproductive-health/rtis/reuse.en.html

5. Is the inner ring uncomfortable for me or my partner?

Some women do report that the inner ring is uncomfortable. If it is, you can try to place the FC differently (i.e., reinsert or re-position the device) so that the inner ring is tucked back behind the cervix and out of way. However, some people report that both the inner and outer rings add to both a man's and a woman's sexual pleasure.

6. Is the FC big?

There may be an initial negative reaction to the FC because of its size, but this feeling diminishes with use. It is useful to compare the FC to an unrolled male condom to highlight that the FC is the same length but wider than the male condom. It is also important to note that the FC provides added protection because the base of the penis and the external female genitalia are partly covered during use. To reduce potential negative reactions, some programs have suggested introducing the FC rolled up to minimize its size; inserting the FC before the initiation of sexual activity; and stressing the advantages of the wider diameter, as many men complain about the constricting nature of male condoms.

7. How do I dispose of the FC?

The proper removal and disposal of female condoms should be included with the packaging of the FC as well in introductory training programs:

- The FC does not need to be removed immediately after a man's ejaculation, like the male condom. But it should be taken out before the woman stands up to avoid the semen spilling out.
- The outer ring should be twisted to seal the condom so that no semen comes out.
- The FC can be pulled out and wrapped in the package it came in and/or in tissue.
- The FC should be disposed of in waste containers and not in the toilet.
- Also, since in many countries women dispose of sanitary napkins in a clean and private way, the same procedures can be promoted for the disposal of FC.

8. Can I use female condoms in different sexual positions?

The FC can be used in any sexual position; however, additional lubricant may be needed. Some women may feel more comfortable learning to use the FC in the missionary position, and then adding other positions after that. Group counseling sessions are often ideal for women to learn from each other how to use the device while having sex in different positions.

The FC is not specifically approved or recommended for anal sex, but there are reports from all over the world that it is used for anal sex. Several studies have been done and published and others are ongoing. The polyurethane of an FC is stronger than latex and can be used with any kind of lubricant.

9. Can we use a female condoms and a male condom at the same time?

You should not use both condoms at the same time. Using the condoms simultaneously may cause friction resulting in either one or both of the condoms slipping or tearing, and/or the outer ring of the FC being pushed inside the vagina.

10. How long will the FC last?

The United States Food and Drug Administration has approved the FC for a shelf life of 5 years from the date of manufacture. Because of the properties of polyurethane, the FC is not affected by differences in temperature and humidity, so no special storage conditions are required.

11. Who can use the FC?

- People who want to protect themselves and their partners from unintended pregnancy and STIs, including HIV/AIDS, and show their partners that they care
- People whose partners cannot or will not use the male latex condom
- Women who are menstruating
- Women who have recently given birth
- Women who have had a hysterectomy
- Women who are peri- and post-menopausal
- People who are allergic or sensitive to latex
- People who are HIV+ or have HIV+ partners

CHECKLIST 17.4: CONDOM USE (MALE) AND DISPOSAL

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR CONDOM USE AND DISPOSAL	
STEP	SCORE
GETTING READY	
1. Collect male condom and penis model (and vagina model if available).	
2. Greet the client respectfully.	
PROCEDURE	
3. Tell the client that you are going to demonstrate condom use and reasons for condom use.	
4. Introduce the condom, identifying the penis model to the client.	
5. Check the expiry date and if the condom cover is intact.	
6. Push the condom to the side of the package, open the package at the marking and take the condom out.	
7. Pinch the tip of the condom and unroll to the base of the (erect) penis.	
8. State that the condom should be used once, and demonstrate proper insertion and removal from vagina model (or fisted hand).	
9. Roll off condom before penis loses erection.	
10. Place in tissue paper and dispose in waste bin.	
CHECK FOR CLIENT UNDERSTANDING	
12. Have the client re-demonstrate condom use and disposal and coach/repeat steps where needed.	
13. Perform hand hygiene.	
14. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO TEACH MALE CONDOM USE AND DISPOSAL

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (*in case of need to remediate or other*):

CHECKLIST 17.5: DMPA PROVISION

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR DMPA PROVISION	
STEP	SCORE
GETTING READY	
1. Prepare the necessary equipment.	
2. Greet the woman respectfully	
3. Offer the woman a place to sit.	
PROCEDURE	
4. Ensure confidentiality.	
5. Tell the woman what is going to be done and encourage her to ask questions. Listen to what the woman has to say.	
6. Perform hand hygiene.	
ASSESSMENT (Ask/Check Record).	
7. Ask the woman about her reproductive goals and need for contraception.	
8. Take a basic medical and reproductive history of the woman.	
9. Assess the woman's risk for STIs and HIV/AIDS.	
10. Assess the woman's blood pressure and take appropriate action.	
11. Confirm eligibility for DMPA.	
12. Ask the woman what she knows about DMPA and correct any misinformation.	
13. Briefly, giving only the most important information, tell the woman about DMPA.	
14. Instruct the woman about injection schedule and menstrual bleeding changes, and have the woman repeat the instructions to be sure she understands.	
ADMINISTRATION	
15. Perform hand hygiene.	
16. Clean injection site with alcohol or antiseptic solution (if skin is soiled) and allow to dry.	
17. Prepare DMPA for injection.	
18. Confirm that the medication and amount are correct.	
19. Insert needle deep into muscle (deltoid or ventro-gluteal).	
20. Aspirate to make sure the needle is not in a vein, then inject DMPA slowly and remove needle.	

CHECKLIST FOR DMPA PROVISION	
STEP	SCORE
POST-PROCEDURE TASKS	
21. Apply pressure to the injection site with clean cotton; do not rub site.	
22. Place auto-disabled, disposable syringe and needle in puncture-proof container.	
23. Dispose of waste materials.	
POST-PROCEDURE COUNCELING	
24. Instruct the woman to return within 12 weeks for next injection. Give her an appointment date and time.	
25. Perform hand hygiene.	
26. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PROVIDE DMPA

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 17.6: EMERGENCY CONTRACEPTION PROVISION

(To be completed by the **Assessor**)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR EMERGENCY CONTRACEPTION (EC) PROVISION	
STEP	SCORE
GETTING READY	
1. Greet the woman respectfully.	
2. Maintain/ensure confidentiality.	
PROCEDURE	
3. Explain that you will need to conduct a general gynecologic exam, and why (signs of pregnancy and STIs).	
4. Prescribes at least one type of emergency contraception: <ul style="list-style-type: none"> • Postinor-2 (2 tablets), or • Ovrette 40 tablets at once, or • COC (30–35 mcg EE) 4 tablets immediately and 4 tablets 12 hours later, or • COC (50 mcg EE) 2 tablets immediately and 2 tablets 12 hours later. 	
5. Explain how EC should be taken.	
6. Explain the advantages, disadvantages, and possible danger signs associated with complications.	
7. Record counseling and prescription.	
8. Perform hand hygiene.	
9. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PROVIDE EMERGENCY CONTRACEPTION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (*in case of need to remediate or other*):

Oral contraceptives that can be used for emergency contraception

Brand	Company	First Dose ^b	Second Dose ^b (12 hours later)	Ulipristal Acetate per Dose (mg)	Ethinyl Estradiol per Dose (µg)	Levonorgestrel per Dose (mg) ^c
<i>Ulipristal acetate pills</i>						
ella	Watson	1 white pill	None ^b	30	-	-
<i>Progestin-only pills</i>						
Next Choice	Watson	2 peach pills	None ^b	-	-	1.5
Plan B	Teva	2 white pills	None ^b	-	-	1.5
Plan B One-Step	Teva	1 white pill	None	-	-	1.5
<i>Combined progestin and estrogen pills</i>						
Aviane	Teva	5 orange pills	5 orange pills	-	100	0.50
Cryselle	Teva	4 white pills	4 white pills	-	120	0.60
Enpresse	Teva	4 orange pills	4 orange pills	-	120	0.50
Jolessa	Teva	4 pink pills	4 pink pills	-	120	0.60
Lessina	Teva	5 pink pills	5 pink pills	-	100	0.50
Levora	Watson	4 white pills	4 white pills	-	120	0.60
Lo/Ovral	Akrimax	4 white pills	4 white pills	-	120	0.60
LoSeasonique	Teva	5 orange pills	5 orange pills	-	100	ceps
Low-Ogestrel	Watson	4 white pills	4 white pills	-	120	0.60
Lutera	Watson	5 white pills	5 white pills	-	100	0.50
Lybrel	Wyeth	6 yellow pills	6 yellow pills	-	120	0.54
Nordette	Teva	4 light-orange pills	4 light-orange pills	-	120	0.60
Ogestrel	Watson	2 white pills	2 white pills	-	100	0.50
Portia	Teva	4 pink pills	4 pink pills	-	120	0.60
Quasense	Watson	4 white pills	4 white pills	-	120	0.60
Seasonale	Teva	4 pink pills	4 pink pills	-	120	0.60
Seasonique	Teva	4 light-blue-green pills	4 light-blue-green pills	-	120	0.60
Sronyx	Watson	5 white pills	5 white pills	-	100	0.50
Trivora	Watson	4 pink pills	4 pink pills	-	120	0.50

CHECKLIST 17.7: LOADING COPPER T IUD IN A STERILE PACKAGE

(To be used by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR LOADING COPPER t IUD IN A STERILE PACKAGE	
STEP	SCORE
1. Make sure the Copper T 380A package is intact and Copper T is not expired.	
2. Load the Copper T 380A while it remains inside the sterile package .	
3. Partially open package (up to one-third) and bend back the package flaps.	
4. Put the white plunger rod inside the inserter tube.	
5. Set the blue depth gauge to the measurement of the uterus.	
6. Place the package on a flat surface.	
7. Slide the white measurement card (which is in the package) underneath the arms of the IUD.	
8. Hold the tips of the IUD arms and push on the inserter tube to assist in bending the arms.	
9. When the arms touch the sides of the inserter tube, pull the inserter tube away from the folded arms of the IUD.	
10. Elevate the inserter tube and push and rotate it to catch the tips of the arms in the tube.	
11. Push the folded arms into the inserter tube to keep them fixed in the tube.	
12. Perform hand hygiene.	
13. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO LOAD THE IUD IN A STERILE PACKAGE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 17.8: IUD INSERTION AND REMOVAL

(To be used by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable=1: The step does not apply in the setting, for example if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR IUD INSERTION AND REMOVAL	
STEP	SCORE
IUD INSERTION	
Pre-Insertion and Insertion Steps (Using aseptic, “no-touch” technique throughout)	
1. Provide an overview of the insertion procedure. Remind the woman to let you know if she feels any pain.	
2. Gently insert the HLD (or sterile) speculum to visualize the cervix (if not already done), and cleanse the cervical os and vaginal wall with antiseptic.	
3. Gently grasp the cervix with an HLD (or sterile) tenaculum and apply gentle traction.	
4. Insert the HLD (or sterile) sound using the “no-touch” technique.	
5. Remove gloves and discard.	
6. Load the IUD in its sterile package.	
7. Set the blue depth-gauge to the measurement of the uterus.	
8. Perform hand hygiene.	
9. Put on new gloves.	
10. Carefully insert the loaded IUD, and release it into the uterus using the “withdrawal” technique.	
11. Gently push the insertion tube upward again until you feel a slight resistance.	
12. Withdraw the rod, and partially withdraw the insertion tube until the IUD strings can be seen.	
13. Gently remove the tenaculum and speculum and place in 0.5% chlorine solution for 10 minutes for decontamination.	
14. Examine the cervix for bleeding.	
15. Ask how the client is feeling and begin performing the post-insertion steps.	

CHECKLIST FOR IUD INSERTION AND REMOVAL	
STEP	SCORE
Post-Insertion Steps	
16. Before removing the gloves, place all used instruments in 0.5% chlorine solution for 10 minutes for decontamination.	
17. Properly dispose of waste materials.	
18. Process gloves according to recommended IP practices.	
19. Perform hand hygiene.	
20. Provide post-insertion instructions (key messages for IUD users): <ul style="list-style-type: none"> • Basic facts about her IUD (e.g., type, how long effective, when to replace/remove) • No protection against STIs; need for condoms if at risk • Possible side effects • Warning signs (PAINS) • Checking for possible IUD expulsion • When to return to clinic 	
IUD REMOVAL	
Pre-Removal Steps	
21. Ask the woman her reason for having the IUD removed.	
22. Determine whether she will have another IUD inserted immediately, start a different method, or neither.	
23. Review the client's reproductive goals and need for STI protection, and counsel as appropriate.	
24. Ensure that equipment and supplies are available and ready to use.	
25. Have the client empty her bladder and swab her perineal area.	
26. Help the client onto the examination table.	
27. Perform hand hygiene	
28. Put new or HLD gloves on both hands.	
Removing the IUD	
29. Provide an overview of the insertion procedure. Remind the woman to let you know if she feels any pain.	
30. Gently insert the HLD (or sterile) speculum to visualize the strings, and cleanse the cervical os and vaginal wall with antiseptic.	
31. Alert the client immediately before you remove the IUD.	
32. Grasp the IUD strings close to the cervix with an HLD (or sterile) hemostat or other narrow forceps.	
33. Apply steady but gentle traction, pulling the strings toward you, to remove the IUD. Do not use excessive force.	
34. Show the IUD to the client.	
35. Place the IUD in 0.5% chlorine solution for 10 minutes for decontamination.	
36. If the woman is having a new IUD inserted, insert it now if appropriate. (If she is not having a new IUD inserted, gently remove the speculum and place it in 0.5% chlorine solution for 10 minutes for decontamination.)	
37. Ask how the client is feeling and begin performing the post-removal steps.	
Post-Removal Steps	
38. Before removing the gloves, place all used instruments and the IUD in 0.5% chlorine solution for 10 minutes for decontamination.	
39. Properly dispose of waste materials.	
40. Process gloves according to recommended IP practices.	

CHECKLIST FOR IUD INSERTION AND REMOVAL	
STEP	SCORE
41. If the woman has had a new IUD inserted, review key messages for IUD users. (If the woman is starting a different method, provide the information she needs to use it safely and effectively [and a back-up method, if needed].)	
42. Perform hand hygiene.	
43. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO INSERT AND REMOVE IUDS

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (*in case of need to remediate or other*):

CHECKLIST 17.8.1: IUD INSERTION

(To be completed by the **Assessor**)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR IUD INSERTION	
STEP	SCORE
GETTING READY	
1. Prepare the necessary equipment.	
2. Greet the client respectfully.	
3. Confirm contraceptive choice.	
4. Offer anticipatory guidance prior to insertion.	
5. Performs hand hygiene.	
PROCEDURE	
6. Ensure that the woman has no contraindications to IUD use.	
7. Explain IUD advantages, disadvantages, side effects, and warning signs.	
8. Explain steps needed for immediate preparation of the woman (empty bladder, cleanse genitals, comfortable positioning, etc.).	
9. Perform bimanual pelvic examination.	
10. Insert speculum and visualizes cervix.	
11. Gently grasp cervix with tenaculum.	
12. Determine depth of uterus and set depth gauge on IUD appropriately.	
13. Appropriately insert IUD.	
14. Perform post-insertion infection prevention: place equipment in decontamination solution, dispose of waste appropriately, and wash hands.	
15. Assess the woman to ensure that she has tolerated insertion.	
16. Provide post-procedure education including: possible side effects, warning signs (PAINS), string check, and when to return to clinic (3–6 weeks).	
17. Perform hand hygiene.	
18. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM IUD INSERTION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 17.9: JADELLE® INSERTION AND REMOVAL

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR JADELLE INSERTION AND REMOVAL	
STEP	SCORE
INSERTION OF JADELLE RODS	
Getting Ready	
1. Tell the client what is going to be done and encourage her to ask questions.	
2. Ask about allergies to antiseptic solution or local anesthetic.	
3. Determine that required sterile or high-level disinfected instruments and JADELLE® rods are present, intact, and not expired.	
Pre-Insertion Steps	
4. Perform hand hygiene.	
5. Put sterile or high-level disinfected gloves on both hands. (If powdered, remove powder from glove fingers.)	
6. Prep insertion site with antiseptic solution.	
7. Place sterile or clean surgical drape over arm (if available).	
8. Inject a small amount of local anesthetic (1% without epinephrine) just under skin; raise a small wheal.	
9. Advance needle about 5 cm and inject 1 mL of local anesthetic in a subdermal track.	
10. Check for anesthetic effect before making skin incision.	
Insertion	
11. Make a shallow, 2-mm incision with scalpel just through skin. (Alternatively, insert trocar directly through the skin without making an incision.)	
12. Advance trocar and plunger to mark nearest the hub of the trocar.	
13. Remove plunger and load rod into trocar with gloved hand or forceps.	
14. Reinsert plunger and advance it until resistance is felt.	
15. Hold plunger firmly in place with one hand and slide trocar out of incision until it reaches plunger handle.	
16. Withdraw trocar and plunger together until the mark nearest the trocar tip just clears incision. (Do not remove trocar from incision.)	
17. Move tip of trocar away from end of rod and hold rod out of the path of the trocar.	
18. Redirect trocar about 15° and advance trocar and plunger to mark nearest hub of trocar.	
19. Place the second rod using the same technique.	

CHECKLIST FOR JADELLE INSERTION AND REMOVAL	
STEP	SCORE
20. Palpate the ends nearest the shoulder and incision to make sure rods are placed correctly.	
21. Remove trocar only after insertion of second rod.	
Post-Insertion Steps	
22. Wipe the client's skin with alcohol.	
23. Bring edges of incision together and close it with Band-Aid or surgical tape with sterile cotton.	
24. Apply pressure dressing snugly.	
25. Dispose of waste materials in leak-proof container or plastic bag.	
26. Remove by turning inside out. Discard gloves in leak-proof container or plastic bag.	
27. Perform hand hygiene.	
28. Complete client record, including drawing position of rods.	
Post-Insertion Counseling	
29. Instruct the client regarding wound care and schedule a return visit appointment in 1 week.	
30. Discuss what to do if client experiences any problems following insertion or side effects.	
31. Ask the client to repeat instructions and answer the client's questions.	
32. Assure the client that she can have rods removed at any time she desires.	
33. Observe the client for at least 15 minutes before sending her home.	
JADELLE REMOVAL	
Pre-Removal Counseling	
34. Greet the client respectfully and with kindness.	
35. Ask the client her reason for removal and answer any questions.	
36. Review the client's reproductive goals and ask if she wants another set of JADELLE® rods.	
37. Describe the removal procedure and what to expect.	
Removal	
Getting Ready	
38. Tell the client what is going to be done and encourage her to ask questions.	
39. Ask about allergies to antiseptic solution or local anesthetic.	
40. Position the woman's arm and palpate rods to determine point for removal incision.	
41. Determine that required sterile or high-level disinfected instruments and supplies are present.	
Pre-Removal Steps	
42. Perform hand hygiene.	
43. Put sterile or high-level disinfected surgical gloves on both hands. (If powdered, remove powder from glove fingers.)	
44. Prep removal site with antiseptic solution.	
45. Place sterile or clean surgical drape over arm (optional).	
46. Inject small amount of local anesthetic at the incision site and under the end of the rods.	
47. Check for anesthetic effect before making skin incision.	
Removal: Standard Method	
48. Make a small incision in the skin on the inside of the upper arm, near the site of the insertion.	
49. Use an instrument to pull out each implant.	
50. Check to make sure two complete rods have been removed and show them to the client.	

CHECKLIST FOR JADELLE INSERTION AND REMOVAL	
STEP	SCORE
Post-Removal Steps	
51. Press down on incision with gauzed finger to stop bleeding and remove the drape, if used.	
52. Bring edges of incision together and close it with Band-Aid or surgical tape with sterile cotton.	
53. Apply pressure dressing snugly.	
54. Dispose of waste materials in leak-proof container or plastic bag.	
55. Remove gloves by turning inside out. Discard gloves in leak-proof container or plastic bag.	
Post-Removal Counseling	
56. Instruct client regarding wound care and schedule a return visit appointment in 1 week.	
57. Discuss what to do if client experiences any problems and answer any questions.	
58. Counsel client regarding new contraceptive method, if desired.	
59. Help client obtain new contraceptive method or provide temporary method until method of choice can be started.	
60. Observe client for at least 15 minutes before sending her home.	
61. Perform hand hygiene.	
62. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PROVIDE JADELLE IMPLANTS

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

17.10: LAM COUNSELING GUIDE



LAM

Lactational Amenorrhea Method

A Family Planning Method
for Breastfeeding Women

Counseling Guide

for Teaching Women
How to Use LAM

Explain Who Can Use LAM

You can use LAM if you meet ALL 3 of these criteria:

1

Your menstrual bleeding has not returned since your baby was born.



Why?

When you begin menstrual bleeding you are fertile again. You can get pregnant even if you continue to breastfeed.

2

You breastfeed your baby day and night and do not give any other food, water or liquids.



Why?

When your baby receives any food, water or other liquids besides breast milk, **your baby will not nurse as often.** This will cause you to be fertile again. You can get pregnant.

3

Your baby is less than 6 months old.



Why?

When your baby turns 6 months old you may be fertile again. You can get pregnant, even if you continue to breastfeed.

Explain How to Use LAM



Breastfeed Regularly

- Breastfeed as often as your baby wants, day and night.
- Continue to breastfeed even when you or your baby is sick.



Breastfeed Only

- Do not give your baby any foods, water, or other liquids before 6 months of age.
- Medicines, vitamins and vaccines are okay.
- Breastfeeding provides your baby with everything she/he needs to be healthy for the first 6 months.
- Do not use bottles, pacifiers or other artificial nipples. These discourage your baby from breastfeeding as frequently.



Begin Thinking About Another Method Now

- When your menstrual bleeding returns, start using another method.
- If your baby receives other food or liquids besides breastmilk, start using another method.
- When your baby reaches 6 months old, start using another method.

Breastfeeding alone is not enough to protect you from pregnancy. All 3 criteria must be met.

Encourage the woman to start thinking about other methods now, to be ready when LAM no longer works for her.

Review other methods.

Explain Who Can NOT Use LAM

These women are fertile again and need to start using another family planning method immediately:



A mother who has begun her menstrual bleeding cannot use LAM.

Bleeding after the baby is 2 months old is considered menstrual bleeding.

OR



A mother whose baby receives other foods or liquids cannot use LAM.

Even if the baby is still breastfeeding.

OR



A mother whose baby is 6 months or older cannot use LAM.

NONE of these women can use LAM.

Counsel the Woman Who Cannot or Chooses Not to Use LAM

1. Encourage her to start using another method now.
2. Help her choose another method.
3. Encourage her to continue breastfeeding her baby.
4. Encourage her to wait until her baby is at least two years old before getting pregnant again.



Other Family Planning Methods for Breastfeeding Women

Methods women can use any time:

- Condoms
- Vasectomy

Methods women can start using 6 weeks after giving birth:

- Progestin-only pills, injectable, implants
- IUD*
- Tubal ligation**

Methods women can use 6 months after giving birth:

- Combined pills (with estrogen)
- Combined injections (with estrogen)
- Natural methods (if specific criteria are met)



*An IUD can be inserted up to 48 hours after giving birth or after 6 weeks postpartum.

**Tubal ligation can be performed up to 7 days after giving birth or after 6 weeks postpartum.

Encourage the woman to wait at least 2 years before getting pregnant again. Waiting 2 years is best for the health of the baby and the woman.



Family Planning Initiative
Addressing unmet need for postpartum family planning



LAM

Lactational Amenorrhea Method

A Family Planning Method for Breastfeeding Women

LAM can help you prevent pregnancy if you are breastfeeding and meet ALL these criteria.

1

No menstrual bleeding since your baby was born



2

You only breastfeed your baby
(no other food or liquid is given)



3

Baby is less than 6 months old



Do YOU meet all 3 of these criteria?

If yes, you can use LAM to prevent pregnancy.

When you no longer meet ALL these criteria, begin using another family planning method immediately.

While You Are Using LAM:



Breastfeed as often as your baby wants, day and night.



Do not give any foods or other liquids (not even water). Breast milk is all your baby needs to grow and be healthy for the first 6 months.



Continue to breastfeed even when you or your baby is sick.

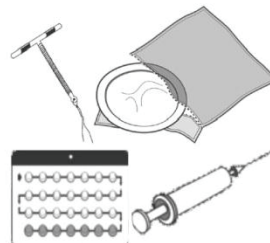
Begin thinking about a new method while still using LAM.

Be ready to switch to a new method immediately, when you no longer meet ANY of the 3 LAM criteria.

The best methods for breastfeeding women are condoms, IUD, tubal ligation, vasectomy, and some pills and injections.

A health care provider can help you choose the best method for you.

When you start using another method, continue to breastfeed. **Breast milk is the best food for your baby!**



Wait 2 years after your baby is born before getting pregnant again. It is good for the health of your baby and you.



Family Planning Initiative
Addressing unmet need for postpartum family planning

CHECKLIST 17.11: ASSESSMENT AND COUNSELING FOR PROGESTIN-ONLY PILL CONTRACEPTIVE USE

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable=1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR ASSESSMENT AND COUNSELING FOR PROGESTIN-ONLY PILL CONTRACEPTIVE USE	
STEP	SCORE
GETTING READY	
1. Prepare the necessary equipment.	
2. Greet the woman, by name, with respect and kindness. Introduce yourself.	
3. Offer the woman a place to sit.	
4. Ensure confidentiality.	
5. Tell the woman what is going to be done and encourage her to ask questions. Listen to what the woman has to say.	
ASSESSMENT (Ask/Check Record)	
6. Ask the woman about her reproductive goals and need for contraception.	
7. Take a reproductive and basic medical history of the woman.	
8. Assess the woman's risk for STIs and HIV/AIDS.	
9. Assess the woman's blood pressure and take appropriate action.	
10. Ask the woman what she knows about the pill (progestin-only pill or “Mini Pill”) and correct any misinformation.	
11. Briefly, giving only the most important information, tell the woman about the pill.	
12. Instruct the woman about how to take the pill and stress that effectiveness increases if she can take it <i>at the exact same time every day</i> .	
13. Have the woman repeat instructions.	
14. Ask the woman if she has any questions. Answer any questions she has.	
15. Confirm eligibility for the method.	
16. Provide the woman with the pill.	
17. Discuss return visits and follow-up with the woman; review side effects and warning signs. Schedule a follow-up visit in 3 months to make sure that the woman is not having any problems with the pill but otherwise give her a year supply.	
18. Perform hand hygiene.	
19. Document procedure and/or findings.	

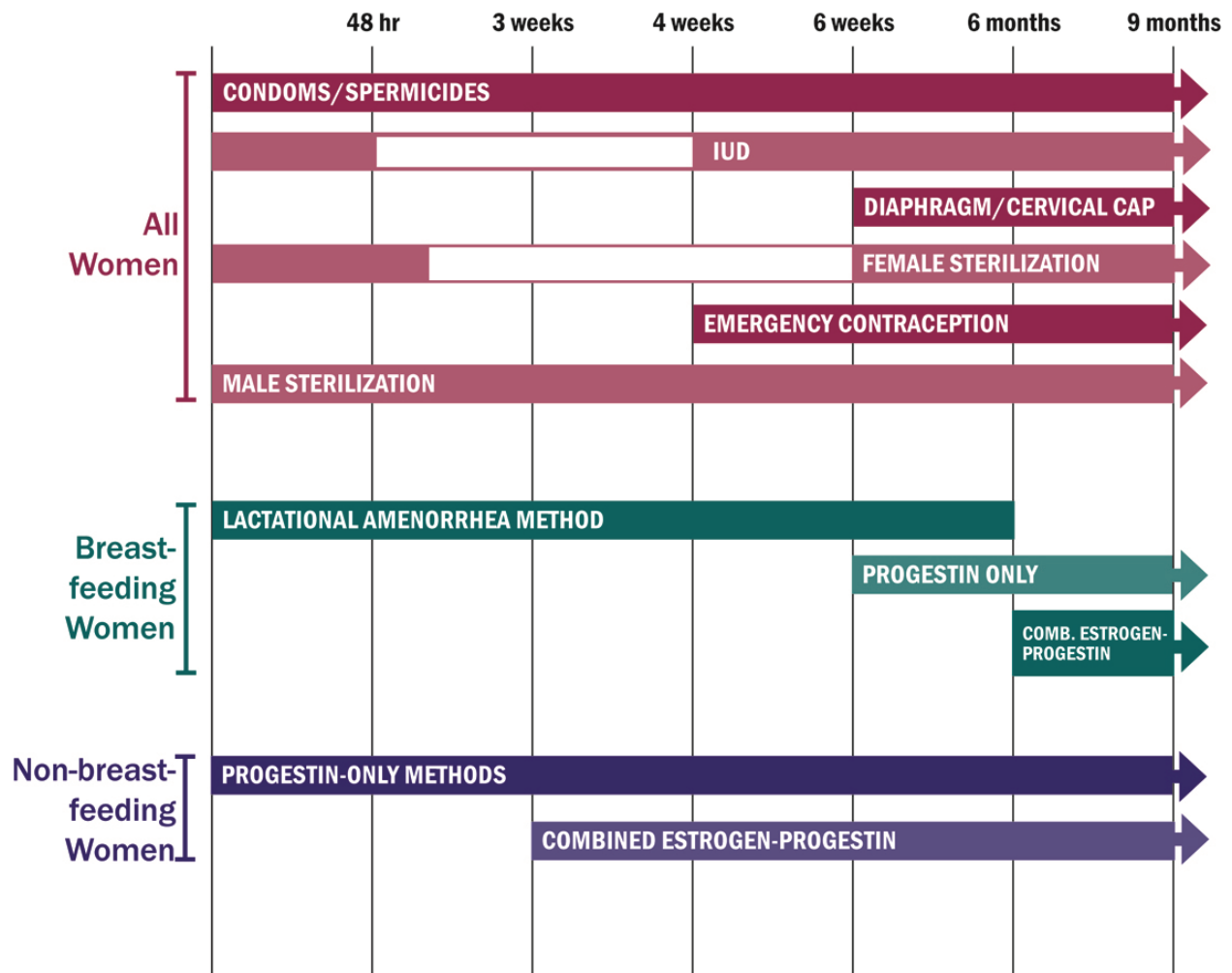
Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PROVIDE ASSESSMENT AND COUNSELING FOR
PROGESTIN-ONLY PILL CONTRACEPTIVE USE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

17.12: POSTPARTUM CONTRACEPTIVE OPTIONS



CHECKLIST 18: GASTRIC LAVAGE

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR GASTRIC LAVAGE	
STEP	
GETTING READY	SCORE
1. Greet the patient and relatives by name and introduce yourself respectfully.	
2. Verify the patient's identity by checking name tag and compare with the client's chart.	
3. Explain to the patient or relatives clearly the purpose of gastric lavage, and answer honestly any question that the patient or relatives ask.	
4. Verify order: Check the patient's chart for physician's order.	
5. Assemble all needed materials on a tray.	
PROCEDURE	
6. Wash hands.	
7. Put on gloves.	
8. Irrigate NG tube.	
9. Measure the require amount of solution.	
10. Skillfully instill solution into NG tube.	
11. Withdraw the same amount of solution that was instilled.	
12. Repeat as require.	
13. Secure NG tube.	
14. Properly discard all used materials.	
15. Properly remove and dispose of gloves.	
16. Perform hand hygiene after the removal of gloves.	
17. Monitor patient for possible problem.	
18. Record and report relevant data.	
19. Make plan for continue care of NG tube.	
20. Report all findings to Charge Nurse.	
21. Perform hand hygiene.	
22. Document procedure and/or findings.	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM GASTRIC LAVAGE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

19.1: MANAGEMENT OF THE SICK CHILD AGE 2 MONTHS UP TO 5 YEARS

Name: _____ Age: _____ Weight: _____ kg Temperature: _____ °C

ASK: What are the infant's problems? _____ Initial visit? ____ Follow-up visit? ____

ASSESS (Circle all signs present)

CLASSIFY

CHECK FOR GENERAL DANGER SIGNS	General danger signs present?	
NOT ABLE TO DRINK OR BREASTFEED VOMITS EVERYTHING CONVULSIONS	LETHARGIC OR UNCONSCIOUS CONVULSING NOW	Yes ___ No ___ Remember to use danger sign when selecting classifications
DOES THE CHILD HAVE COUGH OR DIFFICULT BREATHING? Yes ___ No ___		
<input type="checkbox"/> For how long? ___ Days	<input type="checkbox"/> Count the breaths in one minute. _____ breaths per minute. Fast breathing? <input type="checkbox"/> Look for chest indrawing. <input type="checkbox"/> Look and listen for stridor.	
DOES THE CHILD HAVE DIARRHEA? Yes ___ No ___		
<input type="checkbox"/> For how long? ___ Days <input type="checkbox"/> Is there blood in the stools?	<input type="checkbox"/> Look at the child's general condition. Is the child: Lethargic or unconscious? Restless or irritable? <input type="checkbox"/> Look for sunken eyes. <input type="checkbox"/> Offer the child fluid. Is the child: • Not able to drink or drinking poorly? • Drinking eagerly, thirsty? <input type="checkbox"/> Pinch the skin of the abdomen. Does it go back: Very slowly (longer than 2 seconds)? Slowly?	
DOES THE CHILD HAVE FEVER? (by history/feels hot/temperature 37.5°C or above) Yes ___ No ___		
Decide malaria risk: High Low <input type="checkbox"/> For how long? ___ Days <input type="checkbox"/> If more than 7 days, has fever been present every day? <input type="checkbox"/> Has child had measles within the last 3 months?	<input type="checkbox"/> Look or feel for stiff neck. <input type="checkbox"/> Look for runny nose. Look for signs of measles: <input type="checkbox"/> Generalized rash, and <input type="checkbox"/> One of these: cough, runny nose, or red eyes.	
If the child has measles now or within the last 3 months:	<input type="checkbox"/> Look for mouth ulcers. If Yes, are they deep and extensive? <input type="checkbox"/> Look for pus draining from the eye. <input type="checkbox"/> Look for clouding of the cornea.	
DOES THE CHILD HAVE AN EAR PROBLEM? Yes ___ No ___		
<input type="checkbox"/> Is there ear pain? <input type="checkbox"/> Is there ear discharge? If Yes, for how long? ___ Days	<input type="checkbox"/> Look for pus draining from the ear. <input type="checkbox"/> Feel for tender swelling behind the ear.	

THEN CHECK FOR MALNUTRITION AND ANAEMIA		
	THEN CHECK FOR MALNUTRITION AND ANEMIA <ul style="list-style-type: none"> Look for edema of both feet. Look for visible severe malnutrition or very low weight. Look for palmer pallor. Severe palmer pallor? Some palmer pallor? Yes ____ No ____ Determine MUAC. MUAC < 12 cm & \geq 11.5cm ____ MUAC < 11.5cm ____ 	
CHECK THE CHILD'S IMMUNIZATION STATUS Circle immunizations needed today. <div style="display: flex; justify-content: space-around;"> ____ BCG ____ Penta ____ 1 Penta 2 ____ Penta 3 </div> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> ____ OPV 0 ____ OPV 1 ____ OPV 2 ____ OPV 3 ____ Measles ____ Yellow fever </div>		Return for next immunization on: _____ (Date)
ASSESS CHILD'S FEEDING IF CHILD HAS ANEMIA OR VERY LOW WEIGHT OR IS LESS THAN 2 YEARS OLD		
ASK—What foods do you give your child? Do you breastfeed your child? Yes ____ No ____ How many times do you breast feed during the day? Is the position and attachment correct? Yes ____ No ____ (Observe the child breastfeeding.) Does the child take any other food or fluids? Yes ____ No ____ If yes, what food or fluids? _____ How many times per day? ____ times. How many types during the day? How many times a day do you feed the child? Less than 4 ____ More than 4 ____ Which quantity do you give each time? What is the consistency of the porridge? _____ Does the child receive his/her own serving? _____ How is the food prepared? _____ Who feeds the child and how? _____ During the illness, has the child's feeding change? Yes ____ No ____ If yes, how? _____		FEEDING PROBLEMS

ASSESS OTHER PROBLEMS:

ASSESS MOTHER'S OWN HEALTH:

CHECKLIST FOR NASOGASTRIC GAVAGE PROCEDURE	
STEP	SCORE
24. Perform hand hygiene.	
25. Document procedure and/or findings.	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM GASTRIC GAVAGE PROCEDURE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (*in case of need to remediate or other*):

TREAT

Remember to refer any child who has a danger sign and no other severe classification.

Note: You will learn to complete this section in COUNSEL THE MOTHER.

Return for follow-up in: _____

Advise mother when to return immediately.

Give any immunizations needed today: _____

Feeding advice: _____

Note: You will learn to complete this section in COUNSEL THE MOTHER.

19.2: MANAGEMENT OF THE SICK YOUNG INFANT FROM BIRTH UP TO 2 MONTHS

Name: _____ Age: _____ Weight: _____ kg Temperature: _____ °C

ASK: What are the infant's problems? _____ Initial visit? ____ Follow-up visit? ____

ASSESS (Circle all signs present)

CLASSIFY

CHECK FOR POSSIBLE BACTERIAL INFECTION		
<input type="checkbox"/> Has the infant had convulsions?	<input type="checkbox"/> Count the breaths in 1 minute. _____ breaths per minute Repeat if elevated _____ Fast breathing? <input type="checkbox"/> Look for severe chest in-drawing. <input type="checkbox"/> Look for nasal flaring. <input type="checkbox"/> Look and listen for grunting. <input type="checkbox"/> Look and feel for bulging fontanelle. <input type="checkbox"/> Look for pus draining from the ear. <input type="checkbox"/> Look at umbilicus. Is it red or draining pus? Does the redness extend to the skin? <input type="checkbox"/> Check for fever (temperature 37.5°C or feels hot) or low body temperature (below 35.5°C or feels cool). <input type="checkbox"/> Look for skin pustules. Are there many or severe pustules? <input type="checkbox"/> See if young infant is lethargic or unconscious. <input type="checkbox"/> Look at young infant's movements. Less than normal?	
DOES THE YOUNG INFANT HAVE DIARRHEA? Yes _____ No _____		
<input type="checkbox"/> For how long? _____ Days <input type="checkbox"/> Is there blood in the stools?	<input type="checkbox"/> Look at the young infant's general condition: <ul style="list-style-type: none"> • Does the infant move only when stimulated? • Does the infant not move even when stimulated? • Is the infant restless or irritable? <input type="checkbox"/> Look for sunken eyes. <input type="checkbox"/> Pinch the skin of the abdomen. Does it go back: <ul style="list-style-type: none"> • Very slowly (longer than 2 seconds)? • Slowly? 	
THEN CHECK FOR FEEDING PROBLEM OR LOW WEIGHT		
<input type="checkbox"/> Is there any difficulty feeding? Yes _____ No _____ <input type="checkbox"/> Is the infant breastfed? Yes _____ No _____ If Yes, how many times in 24 hours? _____ times <input type="checkbox"/> Does the infant usually receive any other foods or drinks? Yes _____ No _____ If Yes, how often? _____ times <input type="checkbox"/> What do you use to feed the child? _____	<input type="checkbox"/> Determine weight for age. Low ____ Not Low ____	

<p>If the infant has any difficulty feeding, is feeding less than eight times in 24 hours, is taking any other food or drinks, or is low weight for age AND has no indications to refer urgently to hospital:</p>														
<p>ASSESS BREASTFEEDING:</p> <p><input type="checkbox"/> Has the infant breastfed in the previous hour?</p> <p>If infant has not fed in the previous hour, ask the mother to put her infant to the breast. Observe the breastfeed for 4 minutes.</p>	<p><input type="checkbox"/> Is the child well-positioned:</p> <ul style="list-style-type: none"> • with the infant's head and body straight? Yes ___ No ___ • facing her breast, with infant's nose opposite her nipple? Yes ___ No ___ • with infant's body close to her body? Yes ___ No ___ • supporting infant's whole body, not just neck and shoulders? Yes ___ No ___ <p><input type="checkbox"/> Is the infant able to attach? To check attachment, look for:</p> <table border="0"> <tr> <td>• Chin touching breast</td> <td>Yes ___</td> <td>No ___</td> </tr> <tr> <td>• Mouth wide open</td> <td>Yes ___</td> <td>No ___</td> </tr> <tr> <td>• Lower lip turned outward</td> <td>Yes ___</td> <td>No ___</td> </tr> <tr> <td>• areola above than below the mouth</td> <td>Yes ___</td> <td>No ___</td> </tr> </table> <p>Circle one: <i>no attachment at all not well attached good attachment</i></p> <p><input type="checkbox"/> Is the infant suckling effectively (that is, slow deep sucks, sometimes pausing)?</p> <p>Circle one: <i>not suckling at all not suckling effectively</i> <i>suckling effectively</i></p> <p><input type="checkbox"/> Look for ulcers or white patches in the mouth (thrush).</p>	• Chin touching breast	Yes ___	No ___	• Mouth wide open	Yes ___	No ___	• Lower lip turned outward	Yes ___	No ___	• areola above than below the mouth	Yes ___	No ___	
• Chin touching breast	Yes ___	No ___												
• Mouth wide open	Yes ___	No ___												
• Lower lip turned outward	Yes ___	No ___												
• areola above than below the mouth	Yes ___	No ___												
<p>CHECK THE YOUNG INFANT'S IMMUNIZATION STATUS Circle immunizations needed today.</p> <table border="0"> <tr> <td><u>BCG</u></td> <td><u>Penta1</u></td> <td><u>Penta2</u></td> </tr> <tr> <td><u>OPV 0</u></td> <td><u>OPV 1</u></td> <td><u>OPV 2</u></td> </tr> </table>		<u>BCG</u>	<u>Penta1</u>	<u>Penta2</u>	<u>OPV 0</u>	<u>OPV 1</u>	<u>OPV 2</u>	<p>Return for next immunization on:</p> <p>_____</p> <p>(Date)</p>						
<u>BCG</u>	<u>Penta1</u>	<u>Penta2</u>												
<u>OPV 0</u>	<u>OPV 1</u>	<u>OPV 2</u>												

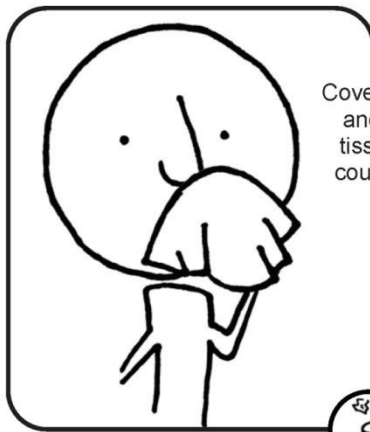
ASSESS OTHER PROBLEMS:

ASSESS MOTHER'S OWN HEALTH:

20.1: COVER YOUR COUGH JOB AID

Stop the spread of germs that make you and others sick!

Cover your Cough



Cover your mouth
and nose with a
tissue when you
cough or sneeze
or

cough or sneeze into
your upper sleeve,
not your hands.



Put your used tissue in
the waste basket.



You may be asked to
put on a surgical mask
to protect others.

Clean your Hands

after coughing or sneezing.



Wash with
soap and water
or

clean with
alcohol-based
hand cleaner.



Minnesota Department of Health
717 SE Delaware Street
Minneapolis, MN 55414
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CHECKLIST 20.2: DECONTAMINATION AND CLEANING OF GLOVES, INSTRUMENTS, AND EQUIPMENT

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR DECONTAMINATION AND CLEANING OF GLOVES, INSTRUMENTS, AND EQUIPMENT	
STEP	SCORE
GETTING READY	
1. Gather equipment and supplies.	
2. Check the concentration (% concentrate) of the chlorine that will be used.	
3. Determine the amount of concentrated chlorine powder (in grams) or solution (in parts) required to make 0.5% chlorine solution.	
4. Determine the amount of water required to mix with the chlorine concentrate to make 0.5% chlorine solution. Note: Refer to the Infection Prevention Manual to determine the appropriate amounts (ratios) of water and chlorine.	
5. Perform hand hygiene and put on clean or utility gloves.	
PROCEDURE	
6. Measure the required amount of chlorine powder or solution. Place into plastic bucket or container.	
7. Slowly add the required amount of water to the chlorine concentrate.	
8. Mix the chlorine and water together. Note: If using powdered chlorine concentrate, first add a small amount of water to the powder, mix to form a paste, and then add the rest of the water.	
9. If the decontamination solution will not be used immediately, cover the bucket or container.	
10. Rinse utility gloves. Remove gloves. Hang gloves to dry.	
11. Perform hand hygiene with soap and water and dry with a clean, dry cloth or air dry.	
Note: New 0.5% chlorine solution should be made when the current solution is visibly dirty or is more than 24 hours old.	

CHECKLIST FOR DECONTAMINATION AND CLEANING OF GLOVES, INSTRUMENTS, AND EQUIPMENT	
STEP	SCORE
Decontamination	
12. Leave on gloves post-procedure (or put on clean utility gloves).	
13. Place all instruments in a plastic container filled with 0.5% chlorine solution immediately after completing procedure. <ul style="list-style-type: none"> Ensure that the 0.5% chlorine solution completely covers the instruments. Note: Caution must be used when decontaminating sharps to avoid injury and to avoid puncturing/damaging gloves. A second plastic container of 0.5% chlorine decontamination solution may be used for sharps.	
14. Dispose of waste material in leak-proof container or plastic bag.	
15. Once all instruments have been placed in decontamination solution, dip gloved hands into solution, then remove gloves by turning inside out and submerge in decontamination solution.	
16. Set timer for 10 minutes or look at clock once all instruments have been placed in decontamination solution.	
17. Perform hand hygiene with soap and water and dry with a clean, dry cloth or air dry.	
18. Put on clean utility gloves.	
19. Decontaminate exam table and/or other surfaces contaminated during procedure by wiping them with 0.5% chlorine solution and a clean rag or cloth.	
20. After 10 minutes, remove instruments, gloves, and equipment from 0.5% chlorine solution.	
21. Rinse in clean running water or place them in plastic bucket or container with water.	
22. Clean instruments immediately (go to cleaning); if unable to clean instruments immediately, continue soaking in water (clean in less than 1 hour to avoid rusting) or towel dry to minimize corrosion and clean as soon as possible.	
23. Cleaning: Leave on utility gloves or put utility gloves on both hands. If available, put on protective eyewear and a plastic apron.	
24. Place instruments in basin with clean water and mild, non-abrasive detergent.	
25. Completely disassemble instruments and/or open instruments with joints.	
26. Wash all surfaces thoroughly using soft brush and/or a cloth. <ul style="list-style-type: none"> Hold instruments under water while washing to prevent splashing and contamination. Thoroughly clean teeth, joints, and screws where organic material can collect. Note: Caution must be used when cleaning instruments to avoid injury and to avoid puncturing/damaging gloves. Glove, instruments, and sharps should be cleaned separately. Note: if an item cannot be cleaned, it cannot be reused and should be discarded.	
27. Perform hand hygiene.	
28. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM DECONTAMINATION AND CLEANING OF GLOVES, INSTRUMENTS, AND EQUIPMENT

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

CHECKLIST 20.3: HAND HYGIENE

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

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Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR HAND HYGIENE	
STEP	SCORE
GETTING READY	
1. Make sure your nails are short (tips are less than 0.5 cm long and you do not wear artificial nails or nail polish).	
2. Remove all jewelry (rings, watches, bracelets).	
3. Do not allow your clothing to touch the sink during handwashing.	
PROCEDURE	
4. Turn on the water and adjust it until it is comfortably warm.	
5. Wet your hands thoroughly up to the wrists.	
6. Apply sufficient soap (bar or liquid) to cover all areas of your hands and thumbs up to your wrists. (If using a soap bar, rinse it and return it to the soap dish.)	
7. Wash your hands up to the wrists with vigorous rubbing, using a circular motion.	
8. Cover all surfaces (front and back of hands, thumbs and between fingers) and continue washing for 15 seconds.	
9. Use the fingernails of the opposite hand or an orange wood stick to clean your nails.	
10. Rinse your hands thoroughly with water covering all areas, especially between the fingers and under your nails.	
11. Dry your hands with a paper towel or clean cloth personal towel.	
12. Use a towel to turn off the water if there is no foot control or automatic shut off to prevent contaminating your hands.	
13. Apply an oil-free lotion to prevent drying and cracking of hands and fingers.	
14. Perform hand hygiene.	
15. Document procedure and/or findings.	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM HAND HYGIENE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (*in case of need to remediate or other*):

CHECKLIST 20.4: HIGH-LEVEL DISINFECTION—BOILING

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR HIGH LEVEL DISINFECTION – BOILING	
STEP	
GETTING READY	SCORE
1. Perform hand hygiene and put on gloves.	
2. Decontaminate and clean all instruments and other items to be HLD.	
3. Immerse items in the water.	
PROCEDURE	
4. Close lid over pan and bring water to a gentle, boiling point.	
5. Start timer. In the HLD log, note time on the clock and record the time when boiling begins.	
6. Boil all items for 20 minutes.	
7. Remove objects with HLD forceps.	
8. Place objects in a high-level disinfected container with a tight-fitting cover.	
9. Perform hand hygiene.	
10. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM HIGH-LEVEL DISINFECTION—BOILING

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (*in case of need to remediate or other*):

CHECKLIST 20.5: HIGH-LEVEL DISINFECTION—STEAMING

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory = 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory = 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable = 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR HIGH-LEVEL DISINFECTION—STEAMING	
STEP	SCORE
GETTING READY	
1. Perform hand hygiene.	
2. Place items in steamer pan with holes in its bottom (to allow the steam to enter).	
PROCEDURE	
3. Place a lid on the top pan and bring the water to a full, rolling boil.	
4. Start the timer when steam appears, or note the time on a clock and record the time in the HLD log.	
5. Steam items for 20 minutes.	
6. Allow items to air dry in the steamer pans (1 to 2 hours) before using.	
7. Using a HLD forceps, transfer the dry items to a dry, HLD container with a tight-fitting cover.	
8. Return all equipment and dispose of disposable materials.	
9. Ensure proper disposal of waste materials.	
10. Perform hand hygiene.	
11. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM HIGH-LEVEL DISINFECTION—STEAMING

Assessor's Signature _____

Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

21: ISOLATION TECHNIQUE

(Source: Tietjen L, Bossemeyer D and McIntosh N. 2003. *Infection Prevention: Guidelines for Healthcare Facilities with Limited Resources*. Jhpiego: Baltimore, MD.

KEY CONCEPTS you will learn in this chapter include:

- What the reasons for the Transmission-Based Precautions are
- What Transmission-Based Precautions are designed to do
- What preventive processes and practices are recommended for each route of infection transmission
- How to effectively use Transmission-Based Precautions

BACKGROUND

Although the spread of infectious diseases in hospitals has been recognized for many years, understanding how to prevent nosocomial (health care facility-acquired) infections and implementing policies and practices that are successful have been more difficult. The transmission of nosocomial infections requires three elements: a **source** of infecting microorganisms, a **susceptible host**, and a **mode of transmission**.

The **human source** of nosocomial infections may be patients, hospital personnel or, less often, visitors. These people may have infectious diseases, be in the incubation period (no symptoms), or may be chronic carriers. Other **sources** of infecting microorganisms are inanimate objects that become contaminated (e.g., examination tables or medical instruments) and the environment, including air and water.

Susceptible hosts are those patients, hospital personnel and, less often, visitors who may become infected. Resistance among people to infecting microorganisms varies; for example, some are immune, others get infected and become asymptomatic carriers; and still others get infected and develop a clinical disease. Factors such as age, underlying diseases, treatment with certain drugs (e.g., antimicrobials, corticosteroids, and other agents that decrease immunity), and irradiation play a role in this process.

The three main routes of infection transmission in hospitals are **airborne**, **droplet**, and **contact**. An infecting microorganism, however, can be transmitted by more than one route. For example, varicella (chicken pox) is transmitted both by the airborne and contact route at different stages of the disease.

In previous sections (**Chapters 1 and 2**), the rationale and fundamentals of the new hospital-based isolation precautions have been laid out. The purpose of this chapter is to further explain how Transmission-Based Precautions are used in the hospital to minimize the risk of clients, patients, visitors, and staff becoming infected (i.e., developing a nosocomial infection) while dealing with the healthcare system.

DEFINITIONS

- **Airborne transmission.** Transfer of particles 5 µm or less in size into the air, either as airborne droplets or dust particles containing the infectious microorganism; can be produced by coughing, sneezing, talking, or procedures such as bronchoscopy or suctioning; can

remain in the air for up to several hours; and can be spread widely within a room or over longer distances. Special air handling and ventilation are needed to prevent airborne transmission.

- **Cohorting.** Practice of placing patients with the same active infectious disease (e.g., chicken pox)—but no other infection—in the same room or ward.
- **Colonization.** Pathogenic (illness- or disease-causing) organisms are present in a person (i.e., they can be detected by cultures or other tests) but are not causing symptoms or clinical findings (i.e., no cellular changes or damage). Coming in contact with and acquiring new organisms, while increasing the risk of infection, usually does not lead to infection because the body's natural defense mechanism (the immune system) is able to tolerate and/or destroy them. Thus, when organisms are transmitted from one person to another, colonization rather than infection is generally the result. Colonized persons, however, can be a major source of transfer of pathogens to other persons (cross-contamination) especially if the organisms persist in the person (chronic carrier), such as with HIV, HBV, and HCV.
- **Contact transmission.** Infectious agent (bacteria, virus, or parasite) transmitted directly or indirectly from one infected or colonized person to a susceptible host (patient), often on the contaminated hands of a health worker.
- **Droplet transmission.** Contact of the mucous membranes of the nose, mouth or conjunctivae of the eye with infectious particles larger than 5 μm in size that can be produced by coughing, sneezing, talking, or procedures such as bronchoscopy or suctioning. Droplet transmission requires close contact between the source and the susceptible person because particles remain airborne briefly and travel only about 1 meter (3 feet) or less.
- **Nosocomial or health care facility-acquired infection (terms used interchangeably).** Infection that is neither present nor incubating at the time the patient came to the hospital. (Nosocomial refers to the association between care and the subsequent onset of infection. It is a time-related criterion that does not imply a cause and effect relationship.)

<p>Note: Protective isolation of immuno-compromised patients, such as those with AIDS, is not an effective way to reduce the risk of cross-infection (Manangan et al. 2001).</p>

TRANSMISSION-BASED PRECAUTIONS

The isolation guidelines issued by CDC in 1996 involve a two-level approach: **Standard Precautions**, which apply to **all clients** and **patients** attending health care facilities, and **Transmission-Based Precautions**, which apply primarily to **hospitalized patients** (Garner and HICPAC 1996). As briefly presented in **Chapter 1**, this system replaces the cumbersome disease-specific isolation precautions with three sets of Transmission-Based Precautions (air, droplet or contact).

In all situations, whether used alone or in combination, Transmission-Based Precautions must be used in conjunction with the Standard Precautions (Garner and HICPAC 1996).

AIRBORNE PRECAUTIONS

These precautions are designed to reduce the nosocomial transmission of particles 5 μm or less in size that can remain in the air for several hours and be widely dispersed (**Table 21-1**).

Microorganisms spread wholly or partly by the airborne route include tuberculosis (TB), chicken pox (varicella virus), and measles (rubeola virus). Airborne precautions are recommended for patients with either **known** or **suspected** infections with these agents. For example, an HIV-infected person with a cough, night sweats, or fever, and clinical or X-ray findings in the lungs should go on airborne precautions until TB is ruled out.

Table 21-1. Airborne Precautions

Used in addition to Standard Precautions for a patient known or suspected to be infected with microorganisms transmitted by the airborne route.

PATIENT PLACEMENT



- Private room.
- Door closed.
- Room air is exhausted to the outside (negative air pressure) using fan or other filtration system.
- If private room not available, place patient in room with patient having active infection with the same disease, but with no other infection (cohorting).
- Check all visitors for susceptibility before allowing them to visit.

Respiratory Protection



- Wear surgical mask.
- If TB known or suspected, wear particulate respirator (if available).
- If chicken pox or measles:
- Immune persons—no mask required.
- Susceptible persons—do not enter room.
- Remove mask after leaving the room and place in a plastic bag or waste container with tight-fitting lid.

PATIENT TRANSPORT



- Limit transport of patient to essential purposes only.
- During transport, patient must wear surgical mask.
- Notify area receiving patient.

Adapted from: ETNA Communications 2000.

Where TB is prevalent, it is important to have a mechanism to quickly assess (triage) patients with suspected TB because delayed diagnosis, resulting in lack of isolation, has been shown to be an important factor in hospital-based transmission to other patients. In this situation, airborne precautions are the last defense in reducing the risk of TB transmission.

DROPLET PRECAUTIONS

These precautions reduce the risks for nosocomial transmission of pathogens spread wholly or partly by droplets larger than 5 μm in size (e.g., *H. influenzae* and *N. meningitidis* meningitis; *M. pneumoniae*, flu, mumps, and rubella viruses). Other conditions include diphtheria, pertussis (whooping cough), pneumonic plague, and strep pharyngitis (scarlet fever in infants and young children).

Using droplet precautions protects the upper respiratory tract as well as conjunctiva of eye and mucous membranes of the mouth and nose. Droplet precautions are simpler than airborne precautions because the particles remain in the air only for a short time and travel only a few

feet; therefore, contact with the source must be close for a susceptible host to become infected (**Table 21-2**).

Table 21-2. Droplet Precautions

Use in addition to Standard Precautions for a patient known or suspected to be infected with microorganisms transmitted by large-particle droplets (larger than 5 μm).

PATIENT PLACEMENT



- Private room; door may be left open.
- If private room not available, place patient in room with patient having active infection with the same disease, but with no other infection (cohorting).
- If neither option is available, maintain separation of at least 1 meter (3 feet) between patients.

RESPIRATORY AND EYE/MUCOUS MEMBRANE PROTECTION



- Wear mask and goggles or face shield if within 1 meter (3 feet) of patient.

PATIENT TRANSPORT



- Limit transport of patient to essential purposes only.
- During transport, patient must wear surgical mask.
- Notify area receiving patient.

Adapted from: ETNA Communications 2000.

CONTACT PRECAUTIONS

These precautions reduce the risk of transmission of organisms from an infected or colonized patient through direct or indirect contact (**Table 21-3**). They are indicated for patients infected or colonized with enteric pathogens (hepatitis A or echo viruses), herpes simplex and hemorrhagic fever viruses, and multidrug (antibiotic)-resistant bacteria. Interestingly, chicken pox is spread both by the airborne and contact routes at different stages of the illness. Among infants there are a number of viruses transmitted by direct contact. In addition, Contact Precautions should be implemented for patients with wet or draining infections that may be contagious (e.g., draining abscesses, herpes zoster, impetigo, conjunctivitis, scabies, lice, and wound infections).

Table 21-3. Contact Precautions

Use in addition to Standard Precautions for a patient known or suspected to be infected or colonized with microorganisms transmitted by direct contact with the patient or indirect contact with environmental surfaces or patient care items.

PATIENT PLACEMENT

- Private room; door may be left open.
- If private room not available, place patient in room with patient having active infection with the same microorganism, but with no other infection (cohorting).

GLOVING

- Wear clean, nonsterile examination gloves (or reprocessed surgical gloves) when entering room.
- Change gloves after contact with infectious material (e.g., feces or wound drainage).
- Remove gloves before leaving patient room.

HANDWASHING

- Wash hands with antibacterial agent, or use a waterless, alcohol-based antiseptic handrub, after removing gloves.
- Do not touch potentially contaminated surfaces or items before leaving the room.

GOWNS AND PROTECTIVE APPAREL

- Wear clean, nonsterile gown when entering patient room if patient contact is anticipated or patient is incontinent, has diarrhea, an ileostomy, colostomy or wound drainage not contained by a dressing.
- Remove gown before leaving room. Do not allow clothing to touch potentially contaminated surfaces or items before leaving the room.

PATIENT TRANSPORT

- Limit transport of patient to essential purposes only.
- During transport, ensure precautions are maintained to minimize risk of transmission of organisms.

PATIENT CARE EQUIPMENT

- Reserve noncritical patient care equipment for use with a single patient if possible.
- Clean and disinfect any equipment shared among infected and noninfected patients after each use.

Adapted from: ETNA Communications 2000.

Empiric Use of Transmission-Based Precautions

If there is any question of an infectious process in a patient without a known diagnosis, implementing Transmission-Based Precautions should be considered based on the patient's signs and symptoms (empiric basis) until a definitive diagnosis is made. Moreover, where health care resources, including laboratory testing, are limited, diagnosis-based isolation precautions are not helpful in practice. In these circumstances, the isolation system needs to be completely based on the clinical findings (signs and symptoms).

Examples of the “empiric use” of these precautions are illustrated in **Table 21-4**.

Table 21-4. Empiric Use of Transmission-Based Precautions (by signs and symptoms)		
AIRBORNE	DROPLET	CONTACT
<ul style="list-style-type: none"> • Cough, fever and upper lobe chest findings (dullness and decreased breath sounds) • Cough, fever and chest findings in any area in HIV-infected person or at high risk for HIV • Rashes (vesicle or pustule) 	<ul style="list-style-type: none"> • Severe, persistent cough during periods when pertussis is present in community • Meningitis (fever, vomiting, and stiff neck) • Hemorrhagic rash with fever • Generalized rash of unknown cause 	<ul style="list-style-type: none"> • Acute diarrhea in an incontinent or diapered patient • Diarrhea in adult with history of recent antibiotic use • Bronchitis and croup in infants and young children • History of infection with multi-resistant organisms (except TB) • Abscess or draining wound that cannot be covered

A complete listing of the clinical syndromes or conditions warranting the empiric use of Transmission-Based Precautions is presented in **Table 21-5**.

The use of these precautions, including their empiric use in selected circumstances, is designed to reduce the risk of airborne-, droplet-, and contact-transmitted infections between hospitalized patients and health care staff. To assist health workers in correctly implementing the appropriate precautions, **Table 21-6** provides a summary of the types of isolation precautions and the illnesses for which each type of precaution is recommended.

Table 21-5. Clinical Syndromes or Conditions to Be Considered for “Empiric Use” of Transmission-Based Precautions

CLINICAL SYNDROME OR CONDITION ^a	POTENTIAL PATHOGENS ^b	EMPIRIC PRECAUTIONS
Diarrhea		
Acute diarrhea with a likely infectious cause in an incontinent or diapered patient	Enteric pathogens ^c	Contact
Diarrhea in an adult with a history of recent antibiotic use	<i>Clostridium difficile</i>	Contact
Meningitis	<i>Neisseria meningitidis</i>	Droplet
Rash or exanthems, generalized, etiology unknown		
Petechial/ecchymotic with fever	<i>Neisseria meningitidis</i>	Droplet
Vesicular	Varicella (chicken pox)	Airborne and Contact
Maculopapular with coryza and fever	Rubeola (measles)	Airborne
Respiratory infections		
Cough/fever/upper lobe pulmonary infiltrate in an HIV-negative patient or a patient at low risk for HIV infection	<i>Mycobacterium tuberculosis</i>	Airborne
Cough/fever/pulmonary infiltrate in any lung location in an HIV-infected patient or a patient at high risk for HIV infection	<i>Mycobacterium tuberculosis</i>	Airborne
Paroxysmal or severe persistent cough during periods of pertussis activity	<i>Bordetella pertussis</i>	Droplet
Respiratory infections, particularly bronchiolitis and croup, in infants and young children	Respiratory syncytial or parainfluenza virus	Contact
Risk of multidrug-resistant microorganisms		
History of infection or colonization with multidrug-resistant organisms ^d	Resistant bacteria ^d	Contact
Skin, wound or urinary tract infection in a patient with a recent hospital or nursing home stay in a facility where multidrug-resistant organisms are prevalent	Resistant bacteria ^d	Contact
Skin or wound infection	<i>Staphylococcus aureus</i> , group A streptococcus	Contact

^a Patients with the syndromes or conditions listed below may present with atypical signs or symptoms (e.g., pertussis in neonates and adults may not have paroxysmal or severe cough). The clinician’s index of suspicion should be guided by the prevalence of specific conditions in the community, as well as clinical judgment.

^b The organisms listed under the column “Potential Pathogens” are not intended to represent the complete, or even most likely, diagnoses, but rather possible etiologic agents that require additional precautions beyond Standard Precautions until they can be ruled out.

^c These pathogens include enterohemorrhagic *Escherichia coli* O157:H7, *Shigella*, hepatitis A and rotavirus.

^d Resistant bacteria judged by the infection control program, based on current state, regional or national recommendations, to be of special clinical or epidemiological significance.

Adapted from: Garner and HICPAC 1996.

Table 21-6. Summary of Types of Precautions and Patients Requiring the Precautions

Standard Precautions

Use Standard Precautions for the care of all patients.

Airborne Precautions

In addition to Standard Precautions, use Airborne Precautions for patients known or suspected to have serious illnesses transmitted by airborne droplet nuclei. Examples of such illnesses include:

- Measles
- Varicella (including disseminated zoster)^a
- Tuberculosis^b

Droplet Precautions

In addition to Standard Precautions, use Droplet Precautions for patients known or suspected to have serious illnesses transmitted by large particle droplets. Examples of such illnesses include:

Invasive *Haemophilus influenzae* type b disease, including meningitis, pneumonia, epiglottitis and sepsis

Invasive *Neisseria meningitidis* disease, including meningitis, pneumonia and sepsis

Other serious bacterial respiratory infections spread by droplet transmission, including:

- Diphtheria (pharyngeal)
- Mycoplasma pneumonia
- Pertussis
- Pneumonic plague
- Streptococcal (group A) pharyngitis, pneumonia, or scarlet fever in infants and young children

Serious viral infections spread by droplet transmission, including:

- Adenovirus^a
- Influenza
- Mumps
- Parvovirus B19
- Rubella

Contact Precautions

In addition to Standard Precautions, use Contact Precautions for patients known or suspected to have serious illnesses easily transmitted by direct patient contact or by contact with items in the patient's environment.

Examples of such illnesses include:

Gastrointestinal, respiratory, skin or wound infections or colonization with multidrug-resistant bacteria judged by the infection control program, based on current state, regional or national recommendations, to be of special clinical and epidemiologic significance.

Enteric infections with a low infectious dose or prolonged environmental survival, including:

- Clostridium difficile
- For diapered or incontinent patients: enterohemorrhagic *Escherichia coli* O157:H7, *Shigella*, hepatitis A or rotavirus

Respiratory syncytial virus, parainfluenza virus or enteroviral infections in infants and young children

Skin infections that are highly contagious or that may occur on dry skin, including:

- Diphtheria (cutaneous)
- Herpes simplex virus (neonatal or mucocutaneous)
- Impetigo
- Major (noncontained) abscesses, cellulitis or decubiti
- Pediculosis
- Scabies
- Staphylococcal furunculosis in infants and young children
- Zoster (disseminated or in the immunocompromised host)^a

Viral/hemorrhagic conjunctivitis

Viral hemorrhagic infections (Ebola, Lassa, or Marburg)*

* See **Appendix I** for a complete listing of infections requiring precautions, including appropriate footnotes.

^a Certain infections require more than one type of precaution.

^b See CDC "Guidelines for Preventing the Transmission of Tuberculosis in Health-Care Facilities."

Adapted from: Garner and HICPAC 1996.

CHECKLIST 22: KANGAROO MOTHER CARE

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR KANGAROO MOTHER CARE	
STEP	SCORE
GETTING READY	
1. Instruct the mother about the necessity of keeping the baby warm with special care.	
2. Explain the benefits of the Kangaroo Mother Care method and ask permission to demonstrate.	
3. Ensure the availability of clothes to keep the baby warm.	
4. Encourage the woman to ask questions and listen to what she has to say.	
PROCEDURE	
5. With the baby naked, keep the baby upright so as to place the baby against the chest of the mother between the breasts.	
6. Turn the head of the baby to one side of the chest so that there is no difficulty in breathing.	
7. Flex all of the baby's limbs such that the baby's face, chest, abdomen, and limbs come in contact with the mother's chest.	
8. Place the baby against the lower part of the mother's chest (near the epigastrium).	
9. Ensure that the cloth that is used for holding the baby to the mother properly supports the baby's buttocks.	
10. Tie the lappa (wrapper) either to the front or back of the mother.	
11. Perform hand hygiene.	
12. Document procedure and/or findings.	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO TEACH KANGAROO MOTHER CARE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (*in case of need to remediate or other*):

CHECKLIST 23: MALARIA RAPID DIAGNOSTIC TEST

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR MALARIA RAPID DIAGNOSTIC TEST	
STEP	SCORE
GETTING READY	
1. Read expiration date.	
2. Use test kit with earliest expiration date <i>(and run controls if due)</i> .	
3. Allow RDT to warm to room temperature if kept in cool storage.	
4. Perform hand hygiene.	
5. Verify request form (by consulting with clinician, if required), date, and time request was received/recorded.	
6. Identify the patient and record the patient's details and laboratory number.	
7. Explain the procedure to the patient, and provide reassurance as needed.	
8. Put on gloves.	
PROCEDURE	
Blood Collection plus Dispensing	
9. Select site, clean with alcohol swab, and allow to dry.	
10. Firmly prick site with sterile lancet.	
11. Collect adequate volume of blood without excessively squeezing the finger chosen.	
12. Dispense blood in correct well.	
RDT Procedure + Reading Results	
13. Dispense correct volume of fluid.	
14. Dispense fluid in correct well.	
15. Wait for correct time (according to manufacturer's instruction).	
16. Verify internal test control.	
Recording Results	
17. Read results correctly.	
18. Record results correctly (including mixed infections if a combo test is used).	
19. Record date and time of reporting results.	

CHECKLIST FOR MALARIA RAPID DIAGNOSTIC TEST	
STEP	SCORE
Disposal of Infectious Material	
20. Dispose of used tests, transfer devices, and other contaminated material into plastic-lined bin.	
21. Dispose of used lancet into a sharps container.	
Result Delivery	
22. Deliver results back to the patient or clinician.	
23. Note time taken from receiving request to delivery of results.	
24. Perform hand hygiene.	
25. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM MALARIA RAPID DIAGNOSTIC TEST

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

24: MANAGEMENT OF PRE-ECLAMPSIA/ECLAMPSIA

Goal: To update knowledge, skills, and attitudes of health care providers on the management of high blood pressure, pre-eclampsia and eclampsia.

Objectives: By the end of the session, trainees will be able to:

- Describe pre-eclampsia according to its classification
- Provide initial management and referral to a woman with pre-eclampsia and/or eclampsia

Overview

Pre-eclampsia and eclampsia are major causes of maternal mortality worldwide. According to the World Health Organization (WHO), hypertensive disorders contribute to about 12% of all maternal mortality. These deaths can be prevented by focused antenatal care (FANC) and appropriate management of severe pre-eclampsia and eclampsia.

Scenario

A 34-year-old woman, gravida 7, came in at 38 weeks' gestation in labor. I had referred her to hospital prior to labor, but she was not admitted even though her BP was 170/100 mm Hg. I admitted her at 7:30 a.m. in labor with cephalic presentation 3/5, cervical os 5 cm, BP 180/100 mm Hg, pulse 90 beats per minute, ankle edema, reflexes good (in the normal range). The woman was complaining of headaches and severe palpitation. A sedative was given and she was immediately transferred to the referral hospital. She delivered a male baby by vacuum extraction in the middle of the night. The baby's condition was satisfactory. The mother was discharged after 4 days. She reported to my maternity ward for follow-up. I also gave her advice on FP and advised her to return within a week to check her BP and for counseling. I felt very competent to manage this case.

Definition of Common Terms Related to Pregnancy-Induced Hypertension and Eclampsia

Women should receive quality antenatal care (ANC) throughout pregnancy. A BP taken prior to 20 weeks of gestation is considered to be a woman's normal or baseline blood pressure. If her blood pressure is above 140/90 mm Hg prior to 20 weeks, she probably has chronic hypertension. Refer this woman to a doctor for evaluation and management of this chronic problem. If you do not know what the woman's baseline blood pressure is, 140/90 mm Hg should be used as the measure of what is abnormal.

- Hypertension in pregnancy: Blood pressure is considered to be raised during pregnancy if:
 - It is 140/90 mm Hg or more
 - The systolic pressure has increased by 30 mm Hg or more
 - The diastolic pressure has increased by 15 mm Hg or more
- Albuminuria/proteinuria: Presence of albumin (a low molecular weight protein) in the urine.
- Pre eclampsia: Development of hypertension and proteinuria during pregnancy.
- HELLP Syndrome: Hemolysis, elevated liver enzymes, and low platelet count is a rare complication of severe forms of hypertension in pregnancy.
- Hyper-reflexia: An exaggerated reaction of a tendon reflex. This occurs if there is edema of the brain in severe pre-eclampsia/eclampsia or there is neurological disease.
- Oliguria: Production of small amount of urine (less than 30 mL/hour).

- Imminent eclampsia/severe pre-eclampsia: Characterized by elevated BP above 160/110 mm Hg, frontal headache, vomiting, blurring of vision (seeing halos around lights/objects), epigastric pain, hyper-reflexia, and oliguria.
- Eclampsia: Occurrence of one or more convulsion(s) in a pregnant or postpartum woman, with hypertension that is not caused by epilepsy, cerebral hemorrhage, cerebral malaria, or other causes of convulsions.

Classification of Pre-Eclampsia (PE)

Mild to Moderate Pre-Eclampsia

A woman is considered to have mild to moderate pre-eclampsia if she has the following symptoms and signs:

Symptoms:

- May have headache

Signs:

- Elevated blood pressure of 140/90 mm Hg to 160/100 mm Hg
- Proteinuria nil or present +
- Normal deep tendon reflexes

Severe Pre-Eclampsia (imminent eclampsia)

A woman is considered to have severe pre-eclampsia if:

Symptoms:

- May have severe headache
- Visual problems such as blurring/double vision or seeing halos around lights/objects
- Epigastric pain and/or vomiting

Signs:

- Rapidly increasing blood pressure equal or above 160/110 mm Hg
- Proteinuria 2+ or more
- Hyper-reflexia
- Oliguria
- Edema of face and hands

Eclampsia—All of the above plus convulsions

Stages of an eclamptic convulsion/fit:

- Prodromal (aura) phase:
 - A woman does not respond to verbal commands
 - Rolls her eyes
 - Lacrimation (eyes produce tears)
- Tonic phase:

- Muscles of the body contract and the body becomes stiff
- Clonic phase:
 - Intermittent muscle contractions and relaxations—convulsions
- Coma:
 - Goes into deep sleep
 - May develop fecal/urine incontinence

Factors associated with pre-eclampsia and eclampsia include:

- Chronic essential hypertension
- Chronic hypertension due to renal and endocrine diseases
- Multiple pregnancy
- Primigravida
- Hydatidiform mole
- Polyhydramnios
- Coarctation of the aorta
- Rh isoimmunization

Differential diagnosis of eclampsia:

Eclampsia may be confused by:

1. Cerebral malaria
2. Epilepsy
3. Meningitis
4. Hypoglycemia
5. Hyponatremia
6. Cerebrovascular hemorrhage from other causes, etc.

Note: Eclampsia should be considered the most likely cause of convulsions in a pregnant woman or a woman who has recently delivered.

Initial Management for Pre-Eclampsia and Eclampsia

Mild to Moderate Pre-Eclampsia

ACTIONS:

1. Advise the patient to get adequate rest at home and avoid strenuous activities.
2. Advise the patient to eat a normal, balanced diet and drink plenty of fluids.
3. REFER within 1 week to hospital for further monitoring of maternal and fetal condition.

<p>Diuretics are not good in treatment because patients with pre-eclampsia and eclampsia have reduced intravascular volume.</p>

Do not prescribe diuretics unless there is pulmonary edema or congestive cardiac failure.

Indications for hospital admission are:

1. A poor obstetric history
2. Evidence of poor fetal growth
3. Gestation age of 37 weeks or more
4. Rest at home not possible
5. Home far from a hospital

Severe Pre-Eclampsia and Eclampsia

Once the diagnosis of severe pre-eclampsia (imminent eclampsia) is made, manage as for eclampsia:

- Shout for help.
- Keep her in left lateral position.
- Protect from injury.
- Ensure the airway is clear—insert an airway if needed.
- Give oxygen 4–6 L/minutes if available.
- Conduct a rapid evaluation of the general condition including vital signs (pulse, blood pressure and respiration).
- Administer magnesium sulfate.

Loading dose:

Give 4 gm (20 mL of 20% solution) intravenous (IV) slowly over 20 minutes; THEN Draw up 10 gm of 50% magnesium sulfate (2 syringes with 10 mL of 50% solution in each) and 1mL of 2% lignocaine injection in the same syringe. Give by deep intramuscular (IM) injection in each buttock, ensuring sterile technique. If it is not possible to give IV dose, the IM dose should be sufficient.

- Commence IV drip Ringer's Lactate or normal saline solution.
- If diastolic BP is >110 give Hydralazine 5 mg IV slowly over 3–4 minutes. If not possible to give IV, give IM. If hydralazine is not available, give nifedipine 5 mg sublingual—if diastolic BP remains elevated at 110, repeat nifedipine 5 mg after 10 minutes but monitor BP closely.
- Aim for diastolic BP between 90–100 mm Hg.
- Catheterize with indwelling urethral catheter and commence intake/output chart.
- Refer to higher level as appropriate.

If the mother is in late labor or referral is not immediately possible:

- Deliver the baby by the quickest and easiest method, within 6–8 hours of onset of fits.
- Give magnesium sulfate 5 gm (i.e., 10 mL of 50%) solution as deep IM injection in alternate buttocks with 1 mL of 2% lignocaine in the same syringe every 4 hours (maintenance dose)
- Monitor vital signs, respiratory rate, reflexes and fetal heart rate every half an hour.

Note: Before repeat administration, check that:

- Respiratory rate is at least 16 per minute.
 - Patellar reflexes are present.
 - Urinary output is at least 25 mL per hour over 4 hours.
-
- Assist second stage of labor by doing vacuum extraction if possible.
 - REFER to hospital with an escorting nurse for further management.

Table 1: Formulation of Magnesium Sulfate

		50% Solution Vial containing 5 g in 10 mL (1 g/2 mL)	20% Solution to make 10 mL of 20% solution Add 4 mL to 50% solution to 6 mL sterile water
IM	5 g	10 mL and 1 mL 2% lignocaine	Not applicable
IV	4 g	8 mL	20 mL
	2 g	4 mL	10 mL

After receiving magnesium sulfate, a woman may feel flushing, thirst, headache, nausea, or may vomit.

In severe pre eclampsia, delivery should take place within 24 hours and preferably within 12 hours.

Toxicity

Toxicity occurs in less than 2% of cases. If respiratory arrest occurs:

- Assist ventilation.
- Give calcium gluconate 1 g (10 mL of 10% solution) by IV injection SLOWLY until respiration begins.

Complications and Effects of Pre-Eclampsia and Eclampsia

Maternal:

- Complications of pre-eclampsia on the mother include:
 - Progression to severe pre-eclampsia and eclampsia
 - Abruptio placentae
 - Multi-systemic organ failure, e.g., liver, kidney, lung, brain, and heart failure
 - Premature labor
 - HELLP Syndrome

- Disseminated intravascular coagulopathy (DIC)
- Maternal death

Fetal complications:

- Intrauterine fetal growth restriction (IUGR)
- Intrauterine fetal death (IUFD)
- Neonatal death due to asphyxia
- Prematurity

CHECKLIST 25: MANAGEMENT OF PROLAPSED CORD

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR MANAGEMENT OF PROLAPSED CORD	
STEP	SCORE
GETTING READY	
1. Tell the woman (and her support person) what is going to be done and encourage them to ask questions.	
2. Provide continual emotional support and reassurance, as feasible.	
3. Give oxygen 4–6 L/minute by face mask or nasal cannula.	
4. Monitor FHT and contractions.	
5. Perform hand hygiene and put on high-level disinfected or sterile gloves.	
PROCEDURE	
6. Place one gloved hand into the vagina and push the presenting part upward.	
7. Hold the presenting part firmly out of the pelvic brim with the abdominal hand until the woman has been prepared for cesarean section.	
8. Remove gloves and discard them in a leak-proof container or plastic bag if disposing of or decontaminate them in 0.5% chlorine solution if reusing.	
9. Perform hand hygiene.	
10. If available, give salbutamol 0.5mg IV slowly over 2 minutes to reduce contraction.	
11. Prepare patient for C/S.	
12. Make sure the woman signs consent form.	
13. Start IVF if it is not started before, if woman is in the second stage of labor.	
14. Carry on delivery with episiotomy and vacuum extraction.	
15. Prepare for resuscitation of the newborn.	
16. Perform hand hygiene.	
17. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM MANAGEMENT OF PROLAPSED CORD

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (*in case of need to remediate or other*):

CHECKLIST 26: MANAGEMENT OF SHOCK

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

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Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR MANAGEMENT OF SHOCK	
STEP	SCORE
GENERAL MANAGEMENT	
1. Shout for help.	
2. Greet the person in shock respectfully, if conscious.	
3. Talk to the person (and her/his support person) and tell them what is going to be done, if conscious, and listen to them and respond attentively to their questions and concerns.	
4. Provide continual emotional support and reassurance, as feasible.	
IMMEDIATE MANAGEMENT	
5. Monitor vital signs every 15 minutes.	
6. Ensure that airway is open.	
7. Give oxygen at 6–8 L/minute by face mask or nasal cannula.	
8. Ensure that he/she is warm.	
9. Elevate the patient's legs.	
BLOOD COLLECTION AND FLUID REPLACEMENT	
10. Perform hand hygiene and put on new examination or high-level disinfected surgical gloves.	
11. Draw blood for hemoglobin, cross-matching, and bedside clotting test before beginning IV infusion.	
12. Infuse IV fluid at the rate of 1 L in 15–20 minutes.	
13. Do a bedside clotting test, as available.	
14. Before removing gloves, dispose of waste materials in a leak-proof container or plastic bag.	
15. Remove gloves and discard them in a leak-proof container or plastic bag if disposing of or decontaminate them in 0.5% chlorine solution if reusing.	
<i>Catheterize bladder if indicated (see Catheterization checklist)</i>	
REASSESSMENT AND FURTHER MANAGEMENT	
16. Reassess the woman's response to IV fluids and adjust rate accordingly.	
17. Continue to monitor vital signs and intake and output closely.	
18. Perform history, physical examination, and tests to determine cause of shock.	

CHECKLIST FOR MANAGEMENT OF SHOCK	
STEP	SCORE
19. Perform hand hygiene.	
20. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO MANAGE SHOCK

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

27: MANAGING COAGULOPATHY JOB AID

Recognizes symptoms of acute postpartum coagulopathy	Bleeding – Bruising of the skin, nose bleed, bleeding gums, bloody urine or stool, bleeding at the IV insertion site Neurologic – Visual disturbance, delirium or coma
Obtains and interprets appropriate diagnostic tests	Platelet count – low and progressively decreasing Fibrinogen – Low (<200) PT & PTT – Clotting time may be prolonged, normal, or short depending on state of the syndrome Peripheral blood smear – Microscopic presence of schistocytes or helmet cells
Transfers client for emergency medical assistance	Replacement of Factor VIII and Fibrinogen Possible heparin therapy

CHECKLIST 28: MANUAL REMOVAL OF PLACENTA

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____ Date _____

CHECKLIST FOR MANUAL REMOVAL OF PLACENTA	
STEP	SCORE
GETTING READY	
1. Prepare the necessary equipment.	
2. Tell the woman (and her support person) what is going to be done, listen to her, and respond attentively to her questions and concerns.	
3. Provide continual emotional support and reassurance, as feasible.	
4. Ask the woman to empty her bladder or insert a catheter.	
5. Give anesthesia.	
6. Give prophylactic antibiotics.	
7. Put on personal protective equipment.	
MANUAL REMOVAL OF PLACENTA	
8. Wash hands thoroughly, including forearms, and put on high-level disinfected or sterile gloves (use elbow-length gloves, if available).	
9. Hold the umbilical cord with a clamp and pull the cord gently.	
10. Place the fingers of one hand into the uterine cavity and locate the placenta.	
11. Provide counter-traction abdominally.	
12. Move the hand back and forth in a smooth, lateral motion until the whole placenta is separated from the uterine wall.	
13. Withdraw the hand from the uterus, bringing the placenta with it while continuing to provide counter-traction abdominally.	
14. Give oxytocin in IV fluid.	
15. Have an assistant massage the fundus to encourage atonic uterine contraction.	
16. If there is continued heavy bleeding, give ergometrine by IM injection or prostaglandins.	
17. Examine the uterine surface of the placenta to ensure that it is complete.	
18. Examine the woman carefully and repair any tears to the cervix or vagina or repair episiotomy.	

CHECKLIST FOR MANUAL REMOVAL OF PLACENTA	
POSTPROCEDURE STEPS	
19. Remove gloves and discard them in a leak-proof container or plastic bag if disposing of or decontaminate them in 0.5% chlorine solution if reusing.	
20. Monitor vaginal bleeding, take the woman's vital signs and make sure that the uterus is firmly contracted.	
21. Perform hand hygiene.	
22. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM MANUAL REMOVAL OF PLACENTA

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 29: MANUAL VACUUM ASPIRATION

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR MANUAL VACUUM ASPIRATION	
STEP	SCORE
INITIAL ASSESSMENT	
1. Greet the woman respectfully.	
2. Assess the patient for shock or complications.	
MEDICAL EVALUATION	
3. Take a reproductive history and perform physical examination and laboratory tests.	
4. Give her information about her condition.	
5. Discuss her reproductive goals.	
GETTING READY	
6. Tell the woman (and her support person) what is going to be done, listen to her and respond attentively to her questions and concerns.	
7. Provide continual emotional support and reassurance, as feasible.	
8. Give paracetamol 500 mg by mouth to the woman 30 minutes before procedure.	
9. Ask about allergies to antiseptics and anesthetics.	
10. Determine that required sterile or high-level disinfected instruments and cannula are present.	
11. Check MVA syringe and charge it (establish vacuum). Ensure that appropriate size cannula and adapters are available.	
12. Check that patient has recently emptied her bladder and washed her perineal area.	
13. Put on personal protective equipment.	
14. Perform hand hygiene and put on high-level disinfected or sterile surgical gloves.	
15. Arrange sterile or high-level disinfected instruments on sterile tray or in high-level disinfected container.	
PRE-PROCEDURE	
16. Give oxytocin 10 units IM.	
17. Perform bimanual examination.	
18. Insert speculum.	
19. Apply antiseptic to cervix and vagina two times.	
20. Remove any products of conception (POC) and check for any cervical tears.	
21. Perform hand hygiene.	

CHECKLIST FOR MANUAL VACUUM ASPIRATION	
STEP	SCORE
MVA PROCEDURE	
22. Explain each step of the procedure prior to performing it.	
23. Put single-toothed tenaculum or vulsellum forceps on lower lip of cervix.	
24. Administer paracervical block (if necessary).	
25. Apply traction on cervix.	
26. Dilate the cervix (if needed).	
27. Insert the cannula gently through the cervix into the uterine cavity.	
28. Attach the prepared syringe to the cannula.	
29. Evacuate contents of the uterus.	
30. When signs of completion are present, withdraw cannula and MVA syringe. Empty contents of MVA syringe into a strainer.	
31. Remove forceps or tenaculum and speculum.	
32. Perform bimanual examination.	
33. Inspect tissue removed from uterus to ensure complete evacuation.	
34. Insert speculum and check for bleeding.	
35. If uterus is still soft or bleeding persists, repeat steps 26–30.	
POST-PROCEDURE TASKS	
36. Before removing gloves, dispose of waste materials in a leak-proof container or plastic bag.	
37. Flush MVA syringe and cannula with 0.5% chlorine solution and submerge in solution for decontamination.	
38. If reusing needle or syringe, fill syringe (with needle attached) with 0.5% chlorine solution and submerge in solution for decontamination. If disposing of needle and syringe, place in puncture-proof container.	
39. Remove gloves and discard them in a leak-proof container or plastic bag if disposing of or decontaminate them in 0.5% chlorine solution if reusing.	
POST-PROCEDURE TASKS	
40. Check for bleeding and ensure cramping has decreased before discharge.	
41. Instruct patient regarding postabortion care.	
42. Discuss reproductive goals and, as appropriate, provide family planning.	
43. Perform hand hygiene.	
44. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM MANUAL VACUUM ASPIRATION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

CHECKLIST 30: MEASURING UPPER ARM CIRCUMFERENCE (MUAC)

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR MUAC	
STEP	SCORE
GETTING READY	
1. Greet the patient respectfully.	
2. Explain procedure to parent/s and child/children in a gentle, soft voice.	
3. Perform hand hygiene.	
PROCEDURE	
4. Locate the mid-point of the upper arm by determining the tip of the shoulder and the tip of the elbow.	
5. Use tape to determine midpoint and lightly mark skin with a pen.	
6. Wrap MUAC tape around midpoint of left arm.	
7. Read the measurement from the window of the tape or from the tape.	
8. Record the MUAC to the nearest 0.1 cm or 1 mm.	
9. Repeat procedure to ensure correct interpretation while communicating to parent/s and child/children what you are doing.	
10. Perform hand hygiene.	
11. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM MEASUREMENT OF UPPER ARM CIRCUMFERENCE (MUAC)

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

31: MEDICATION ADMINISTRATION

INTRODUCTION TO MEDICATION ADMINISTRATION

Medicines and other chemicals, for both diagnostic and therapeutic reasons, can be administered in a wide variety of ways. The administration of drugs concerned the very earliest physicians. The ancient Babylonians (c. 3000 BCE) compounded laxatives, mixing vegetable and animal components with oils and honey for oral administration, and volatile oils were prepared using the newly discovered technique of distillation. Ancient Egyptian papyri (c. 1900–1100 BCE) also mention many medicines prepared as potions, made up in water, milk, or alcohol, or mixed into pills with dough or honey. There were ointments and vapors, and also suppositories and purgatives. These basic methods of administering drugs to patients have remained in use, improved by refinements of preparatory technique—especially with the advent of machinery to compound medicines—and the preparation of purer, unadulterated ingredients. To these have been added techniques for delivery by other routes—most notably that of injecting substances into the body.

The aim of medication administration is for the active components of the medicine to reach the target site where it is intended to be effective. The technique and route used, such as an injection into a muscle, application of a cream to the skin, or ingestion of a pill, are influenced by both the formulation of the compound and the desired site and rapidity of action. An additional constraint is that medicines that could be degraded by natural digestive processes, or which would not be absorbed from the gut, cannot be given by mouth.

Injection and Infusion

Injection is the act of introducing a substance into a body, usually by a syringe and needle. The substance is usually in a liquid form, and is employed to have a therapeutic effect either at the site of application (local actions including cooling, heating, antibiotic, and anti-inflammatory) or elsewhere in the body. Injected drugs usually act more quickly than those taken by mouth, and some substances, such as insulin, need to be injected, because they would be destroyed in the gut. Injections can be made into practically any tissue or cavity of the body, for example, *intra-dermal* (into the skin), *subcutaneous* (just under the skin), *intramuscular* (deep into a muscle), or, less commonly, *intra-peritoneal* (into the peritoneal cavity), or *intra-pleural*. The site used depends on the purpose and the nature of the injection. Injection directly into the bloodstream (*intravenous*) has the most rapid effect—within minutes or even seconds—and so is suited to urgent treatment, such as reviving, by glucose injection, a diabetic person who has had an overdose of insulin. Substances given by intramuscular injection take longer to be absorbed into the circulation. The subcutaneous route (injected into fat tissue) has the slowest effect and, by comparison with the intramuscular route, does not allow as large a volume to be injected without discomfort.

Infusion usually into a vein, but also sometimes into a body cavity, differs from injection in being a continuous, slow introduction of material, usually under pressure of gravity, as in a blood or saline infusion, or transfusion.

Oral Medication

Drugs to be given by mouth are produced in a wide array of formulations, including tablets, capsules, pills, and liquids. Aspirin, and also alcohol, are absorbed in the stomach, but most oral medications are designed to be absorbed in the small intestine, where nutrients are normally absorbed, and they are coated with a protective material so that they pass through the stomach intact.

Fluid mixtures and elixirs have been used for centuries, and provided a convenient method by which a measured dose could be administered to a patient. Pills “balls cut from a solid mass and hand-rolled” and lozenges “shaped pieces also cut from a solid mass” have been known since ancient times. Various coatings were devised to disguise any bitter or unpleasant taste, gold and silver being particularly valued.

Other Routes

Some drugs are best absorbed through mucous membranes—such as the lining of the mouth, especially under the tongue—one of the best known being nitroglycerine for angina. Other sites for absorption can include the rectum, vagina, urethra, or nasal cavity, although these are more often used so that the drug can act locally, as in the case of anti-allergic nasal sprays, vaginal pessaries in the treatment of local infections, and spermicide preparations in contraception. Rectal suppositories are usually bullet shaped, and molded from a substance, such as glycerin, that will slowly dissolve at body temperature, and may be used to carry drugs for absorption as well as the commoner local lubricant function. Some drugs that would normally be given orally may have to be administered through the rectum, in cases where, for example, a patient is vomiting excessively, or is unconscious and unable to swallow. Approximately 50% of a drug can be absorbed through the rectal mucosa, although irritation often occurs. For a period in the nineteenth century, the rectal route was also used to induce anesthesia, being especially favored by Russian military surgeons for the administration of ether.

Ointments are preparations of a fatty or oily consistency, for the application of medicines to the skin or mucous membranes, and are intended either to exert a local effect—such as warming, cooling, pain relief, anti-infection; or to provide a protective barrier—or to be absorbed and spread through the body to have more widespread effects.

Few drugs penetrate readily through the layers of the skin. Absorption is determined by both the surface area over which an ointment is spread, and the solubility of the ointment. Some chemicals, such as toxic substances in organic solvents, can be absorbed rapidly through the skin and cause poisoning. Absorption through skin patches can provide low-maintenance levels of drugs, such as estrogen replacement therapy (a form of hormone replacement therapy) for post-menopausal women, or a patch worn to release anti-motion sickness drugs while a person is traveling. Absorption is enhanced through skin damaged by burns, wound, or abrasion, and particular care must be taken when applying medicaments to such injuries. Ointments are also prepared for application to the eyes, principally for their local effects, usually from absorption through the conjunctiva, often for infections or trauma. More recently, ocular inserts have been developed to provide continuous delivery of low levels of drugs, somewhat analogous to skin patches.

Some drugs can be delivered by *inhalation*, in the form of vapors or aerosols. They can be absorbed rapidly into the circulation through the pulmonary epithelium—the lining of the lungs. This route is used particularly for the treatment of respiratory diseases, such as asthma, and for the administration of volatile anesthetics. Absorption is rapid because of the large surface area of the lungs. The main disadvantages to this route are the difficulties of regulating the dose, and the fact that many of the gases used in this way also act as irritants. This can also be the route for inadvertent absorption of toxic chemicals in the environment, and substances used in chemical warfare, such as mustard gas.

Adapted from: E. M. Tansey (for more information, visit the Web site below)

<http://www.answers.com/topic/drug-administration>

Medications

The following issues may need to be addressed in the administration of medications:

Preparing oral medication (liquids and tablets/pills, unit dose and non-unit dose); mixing and administering insulin; differentiate administering insulin from heparin, differentiate administering low molecular weight heparin (Lovenox) from traditional, unfractionated heparin; administering intramuscular injections (from scenario presented, select appropriate gauge, length of needle, correct syringe, know muscle groups and select an appropriate site, identify and find anatomic landmarks, use correct injection technique); problem solve for typical patient problems; describe all steps needed in administering medications, including the 10 rights; describe how to locate and account for narcotics; identify medications that require double check; and document medication on the medication record.

TEN RIGHTS TO MEDICATION ADMINISTRATION

The health provider administering medication must always follow the rights of medication administration. There are some additional rights that have been added to the five rights. Please consider them.

They are:

1. The right patient
2. The right medication
3. The right dose
4. The right time
5. The right route
6. The right patient education
7. The right to refuse
8. The right assessment
9. The right evaluation
10. The right documentation

PRE-MEDICATION LAB

Objective:

Learners are to become familiar with different types of needles and syringes and learn the basics of handling a needle and syringe.

Key Areas of Concentration:

1. Recognize different sizes and specialty syringes (i.e., differentiate TB syringe, low-dose insulin syringe, and 1 cc insulin syringe from “regular” syringes).
2. Recognize different gauges and lengths of needles. Emphasize that the larger number gauge is finer in diameter, high number gauges are appropriate for SC and pediatric IM, and the low number syringes are appropriate for thick or viscous fluids with adult IM injections.
3. Learn how to put a needle on a syringe and how to take the cap off the needle and replace the cap. Do NOT teach passive scooping to recap a sterile needle. Emphasize that used needles are NOT recapped. (Do not offer variations of times you might recap in this lab; this topic is covered in the lecture.)
4. Learn how to manipulate the plunger of a syringe.
5. Be able to draw up fluid into a syringe.
6. Reconstitution of dry medications may be added to this lab.

Equipment needed at each station:

Several ½-cc insulin syringes

Several 1-cc insulin syringes

Several TB syringes

Several 1-cc syringes without needles

Several 3-cc syringes with 22-gauge needle

Several 3-cc syringes without needles

Several 5-cc syringes

3 or 4 10-cc syringes

1 or 2 60-cc syringes

Several 18-gauge needles

Several 20-gauge needles

Several 22-gauge needles, some 1 inch, some 1½ inch

Several 25-gauge needles

3 Vials of 30-cc normal saline

20 Alcohol pads

Needle/sharps container

Equipment for reconstituting dry meds (see med administration)

MEDICATION ADMINISTRATION—I

Goal: By the end of the lab, the learner will be able to demonstrate basic techniques of safely administering oral medications, recognize medications that are given by routes other than oral or parenteral (IV), learn how to reconstitute dry medications, administer 2 types of insulin in a 1-syringe via the SC route, and practice measuring a blood glucose level with one model of glucometer.

Key areas of concentration:

1. Differentiate unit dose from non-unit dose medications.
2. Differentiate techniques for preparing unit dose and non-unit dose. They should practice with both types. Stress that learners should not open unit dose packs until at bedside.
3. Be able to correctly prepare oral medications. They should measure Maalox or KCL in plastic medicine cups, transfer Tylenol or nitroglycerine tablets to paper medicine cups, and measure baby vitamins with the dropper.
4. Utilize safety precautions and proper technique to "administer" oral medications. Emphasize handwashing, checking patient's ID bracelet, checking the 10 rights, and checking each medicine three times. Learners will need to identify the correct dose of medication from various doses at the station. Practice crushing medicines. Give examples on how to mix with a vehicle (e.g., yogurt). Give them situations to problem solve, for example, patient can't swallow pills, patient refuses medication, patient nauseated but on oral medicines, etc.
5. Demonstrate ability to properly document the administration of oral meds. They should sign off on a practice medication sheet and know how to sign off standing, PRN, and stat orders.
6. Recognize medications that are administered rectally, topically, sublingually, and via otic and ophthalmic routes. Learners should examine samples displayed of various forms and routes of medication, and practice preparing the various forms of nitropaste, i.e., how to measure on papers, how to open backs of patches.
7. Reconstitute dry medication for parenteral administration. **Verify that no learner is allergic to penicillin before starting.*** If a learner is allergic, direct the person to the area that is without penicillin. Emphasize how to select the proper amount of diluent for various concentrations and routes of administration, and how the amount of diluent will not be the same as amount of prepared drug (example: add 3 cc, get 3.5 cc of drug prepared). Give the learner practice problems in selecting the appropriate amount of diluent (example: you need to give this many mg, select the right amount of diluent from the options shown on the label. Also show mix – o-vial (activate 1 per group).
8. On themselves, perform a fingerstick and measure blood glucose level using a glucometer OR use control solutions to obtain a reading. Do NOT allow learners to stick each other. **Have learners sit to do fingerstick.**
9. Correctly draw up and administer insulin into the injection site (rolled up gauze or towel). Emphasize site locations, rotation of injection sites serially (example: several spots in each arm, NOT arm to leg to abdomen), cleaning skin with alcohol, and injection technique. Learners should practice first drawing up only one type of insulin, and then practice drawing up regular and NPH in one syringe. Learners should begin to differentiate the types of insulin and select the appropriate one for the order. **Do NOT teach passive scooping to recap a sterile needle.**

MEDICATION LAB I

Equipment needed:

Oral Medications

- 1 Bottle of liquid baby vitamins
- 1 Multi-dose bottle of Maalox
- 4 Unit dose containers of Maalox
- 1 Multi-dose vial of Tylenol
- 10 Packages single-dose Tylenol
- 1 Multi-dose bottle of KCL elixir
- 4 Unit-dose containers of KCL elixir
- 2 Bottles of nitroglycerine tablets, different doses
- Several packets of miscellaneous, single-dose medications in varied packages
- 2 Emesis basins (to hold single dose medications)
- 1 Stack of plastic medication cups
- 1 Stack of small paper cups
- Procedure list for administering oral medications
- Sample medication records (1 per learner)

Reconstitution Station: may be separate from medication lab; check background schedule

- Bottles of dry medication to be reconstituted (usually ampicillin) (1 per learner)
- Bottles of penicillin that can be reconstituted to various concentrations (3 per station, 1 diluted thick, 1 thin, 1 medium)
- Mix- o-vials (Solucortef): 1 per learner
- 5-cc syringes: 1 per learner
- 10-cc syringes: 10 per station
- 18-gauge needles: 1 per 4 learners
- 20-gauge needles: 1 per learner
- 50 bottles of sterile normal saline
- Alcohol wipes
- Needle box
- Procedure list

*One Reconstitution station designated as the PENICILLIN-FREE station:

- 20 Bottles dry erythromycin
- 20 Vials sterile water
- 20 5-cc syringes with needle
- 20 10-cc syringes with needle
- One **UNOPENED** bottle of penicillin (to observe label instructions)
- Alcohol wipes
- Procedure list

Show and Tell

Multi-dose and unit dose vials of eye drops
Ophthalmic ointment containers
Several Nitrodur patches of various strengths/sizes
Nitrodur applied to an ABD pad as a sample
2 or 3 Extra thick gauze pads
1 or 2 Nitroglycerine tubes of paste and papers
1 of each strength Nitroglycerine tablet bottle
2 Rolls of tape
Alcohol pads
Mortar and pestle
Containers of different types of cream, e.g., silvadene and betadine
Rectal suppositories
Topical xylocaine bottle
Ear bulb
Vials containing solutions that have crystallized
Inhaler and spacer
Box of exam gloves

Glucometers

1 Glucometer
High-, low-control solutions
Box of lancets
Test strips: 3 per 2 learners; ensure they have not expired; match strips to model
Box of plastic pipettes with bulb end
Box of exam gloves
Alcohol wipes: 1 per learner
Box of 2 X 2s
Band-Aids
Red bag and needle box
Wash basin with water and bleach in it, place on chux
Fingerstick procedure
Minimum 3 chairs per station

SC Station

4 Injection sites (rolled up, thick gauze or towel)
Needle box
1-cc insulin syringes (1 per learner)
½-cc insulin syringes (low dose) (2 per learner)
4 Bottles of regular insulin
4 Bottles of NPH insulin
1 Bottle of 70\30 insulin
1 Bottle of pork-based NPH or regular insulin
Procedure list
Medication administration records

ADMINISTRATION OF ORAL MEDICATIONS

Equipment: Client's medication record and chart
Prescribed medication
Medication cups: paper cups for tablets and capsules
Calibrated cups for liquids
Medication tray

1. Check date on medication order and verify its accuracy by checking it against the doctor's order. Employ the 10 rights.
2. Check patient's record for any drug allergies.
3. Gather equipment.
4. Wash your hands.
5. Check label on the medication three times before administering it.
 - When taking container from shelf
 - Just before pouring
 - Before returning container or before discarding wrapper
6. Prepare the correct amount of medication without touching the container and contaminating the medication.
 - If administering tablets from a bottle, pour the required number into bottle cap and transfer to paper cup.
 - If administering unit dose tablets, keep tablets in package; place package directly into small paper cup.
 - If administering a liquid, remove cap and place it upside down to prevent contaminating it. Hold cup at eye level and fill to desired level using level of meniscus as guide.
7. Confirm the client's identity on his/her wristband and compare to patient record.
8. Explain to the client the purpose of the medication and include relevant information about its effects.
9. Assist the patient to a sitting position or, if not possible, a lateral position.
10. Give the client his/her medication and an appropriate liquid as needed.
11. Stay with the client until he/she has swallowed the medication.
12. Perform hand hygiene.
13. Record medication given, dosage, time, and any complaints of the client and signature of the nurse.

ADMINISTRATION OF SUBCUTANEOUS INJECTION (INSULIN)

Equipment: Prescribed medication
 Order or medication record
 Sterile syringe and needle
 Sterile alcohol swabs

1. Follow steps 1–5 listed in administration of oral medication.
2. Prepare and withdraw medication from insulin vial as outlined in previous procedure.
3. Confirm patient's identity.
4. Provide for privacy; position and drape patient.
5. Explain procedure.
6. Select appropriate injection site. (Learner will state possible insulin injection sites.)
7. Cleanse injection site with alcohol swab starting at the center and moving outward in a circular motion.
8. Remove needle cover.
9. With non-dominant hand, grasp skin around site of injection firmly to elevate subcutaneous tissue forming a 1" fat fold.
10. Inform patient that he will feel a prick as needle is inserted.
11. Insert needle quickly at 90° angle (or 45° depending on amount of subcutaneous tissue and size of patient) and release skin.
12. When needle is inserted, move non-dominant hand to barrel of syringe and dominant hand to plunger, or place non-dominant hand on plunger, keeping dominant hand on barrel. Inject medication.
13. Quickly remove needle; cover injection site with alcohol swab.
14. Check site for bleeding and apply Band-Aid if necessary.
15. Dispose of needle and syringe in proper receptacle. Do not recap used needle.
16. Wash your hands.
17. Record medication.

Mixing Insulin

When mixing insulins, the standard procedure used is to draw up short-acting (regular insulin) first, then the intermediate or long-acting insulin (NPH). Regular insulin will be clear. The long-acting insulin, NPH, will be cloudy. (Not all long-acting insulins are cloudy; Lantus (glarginal) and Levemir (determir) are clear.

1. Select ordered insulins.
2. Rotate the vial of NPH between your hands until well mixed.
3. Use an alcohol wipe to cleanse both vial tops.
4. Draw up air for the appropriate amount of NPH and inject this air into NPH vial. Withdraw needle from vial.
5. Draw up air for the appropriate amount of regular insulin and inject this air into the regular insulin vial.
6. Draw up appropriate amount of regular insulin. Withdraw needle from vial.
7. Have someone check dosage.
8. Reinsert needle into NPH vial and draw back appropriate amount of NPH.

*This will require you to draw to the total amount of insulin needed. Do not overdraw, because you cannot return insulin to vial.

9. Withdraw the needle and recap. *Do not use passive scoop technique with a sterile needle.*

10. Have someone check new dosage.
11. Administer using subcutaneous procedure.

Fingerstick Procedure

*** Learners may stick themselves but not each other!**

1. Do not use a site that has been used for a recent/previous fingerstick.
2. DRY the site after cleansing with an alcohol pad. After cleansing the skin/puncture site with the isopropanol, allow the area to air dry, so the antiseptic action of the alcohol can take effect. Residual alcohol causes rapid hemolysis and can have adverse effects on test results. Errors in blood glucose determination caused by contamination with isopropanol have also been reported.
3. Never milk the finger; gentle massage is sufficient to increase the blood flow. Blood flow from the puncture is enhanced by holding the puncture site downward and gently applying intermittent pressure to the surrounding tissue (or proximal to the puncture site when the blood is obtained from a finger). Strong repetitive pressure (milking) must not be applied; it may cause hemolysis or tissue-fluid contamination of the specimen.

Diluting Dry Medication for Injection

1. Determine amount of diluent to be added to achieve correct dose.
2. Clean rubber top of diluent vial and medication vial with alcohol swab.
3. Draw air into syringe equal to amount of diluent to be withdrawn.
4. Inject air into diluent vial and withdraw diluent.
5. Inject diluent into medication vial.
6. Invert medication vial several times to dissolve medication.
7. Draw air into syringe equal to amount of medication to be withdrawn.
8. Inject air into medication vial and withdraw medication.
9. If more than a single dose is available from the medication vial, check vial or package insert to learn expiration time after reconstitution.
10. Check how reconstituted medication should be stored. Usually it is refrigerated after reconstitution.
11. If your institution's medication policy allows reconstituted medications to be saved and used at a later time, label bottle for next nurse. Include: amount and type of diluent added, concentration of mixed medication, expiration date, date and time mixed, and your initials.

MEDICATION ADMINISTRATION—II

Goal: By the end of lab, the learner should be able to demonstrate the techniques for administering medicines by the intradermal and intramuscular routes, and be able to administer insulin by its varied subcutaneous techniques. They should also be familiar with vials and ampules.

Areas of concentration:

1. Recognize various general and special purpose syringes. Understand the reasons for using a certain syringe (for example, size related to amount of medication; measured in units for insulin; tuberculin syringe is 1 cc, therefore also used in pediatrics; skin testing; small doses of heparin SQ, etc.). (The topics are covered in pre-medication lab in fall.)
2. Differentiate needles in terms of gauge, length, usual use and type of patient, and/or medication for which it might be used. Give learners examples of patients (e.g., very thin, obese, pediatric) or sites (e.g., deltoid, dorsogluteal, etc.) and have them select appropriate needles.
3. Differentiate ampules from vials (single-dose and multi-dose) Learners should practice drawing up medicines from these sources. Point out how to get out all of the medicine from these sources.
4. Correctly draw up and administer regular insulin mixed with NPH insulin into a simulated patient (a rolled-up gauze).
5. Correctly draw up and administer an intramuscular injection into a mannequin. Learners should **NOT** inject fluid into mannequins. Learners need to be able to locate anatomical landmarks for all sites. Teach learners that dorsogluteal site is **not** used. Give clinical examples and have them select appropriate site, e.g., obese adult, frail elderly, infant, child.
6. Document administration of subcutaneous and intramuscular injections. They should understand how to sign off narcotics and how to document if wasted or dropped.
7. Practice performing an intradermal injection on the anatomic model. Learners should learn usual site placement, how to hold the skin taut (on a lab partner), correct angle, and creation of a wheal. Optional: Learners may practice on themselves, under direct faculty supervision (see restrictions listed in IM self-practice). Someone else will need to hold the skin taut. Discuss reading and interpreting PPDs.

MEDICATION II

Equipment Needed

IM Injections

1 Mannequin or simulated hip may be used (fruits, towels, or vegetables may also be used)

Needle box

5 5-cc syringes in an emesis basin

15 Each 1-cc syringes no needles in an emesis basin

15 3-cc syringes with 22-gauge needle attached, in an emesis basin

15 3-cc syringes, no needle, in an emesis basin

15 1-cc syringes with 25-gauge needles attached

5 25-g 5/8" needles

15 20-g 1½" needles

15 22-g 1" needles

15 22-g 1½" needles

4 Normal saline bottles (30 cc)

Alcohol pads (3 per learner)

Box of exam gloves (**use is OPTIONAL according to CDC**)

4 Emesis basins for needles/ syringes

Procedure list for IM injections

Subcutaneous Injections

4 Injection sites (rolled-up, thick gauze or towel)

Needle box

3-cc syringes (added this lab) (1 per 2 learners)

1-cc syringes, no needles (added this lab) (1 per 2 learners)

2–3 Bottles of normal saline (30 cc)

1-cc insulin syringes (1 per learner)

0.5cc-insulin syringes (2 per learner)

25-g needle and 1 of any other gauge needle (1 per learner)

2 Bottles of regular insulin

2 Bottles of NPH insulin

1 Bottle of 70/30 insulin

1 Bottle of pork insulin, either NPH or regular

Vials and Ampules

Different size vials of premixed medications (single and multi-dose): 1 per learner

Different size ampules (usually Vitamin K): 1 per learner

3-cc syringes with needles (2 per learner)

Box of alcohol pads

Needle box

Procedure list for withdrawing medicine from vials and ampules

Intradermal Station

2 Injection sites (pad with IV clear site cover to act as skin or arm)

TB syringes with needles (1 per learner)

Alcohol wipes (1 per learner, plus a few extra)

2 Bottles of 30-cc normal saline (MUST be new and unopened)

Needle box

Procedure for Intradermal injection

Procedure of interpreting PPD

Intradermal arm (1 per station)

Model of “positive” PPD

PREPARATION OF MEDICATIONS FROM VIALS AND AMPULES

Equipment: Vial or ampule of medication
Needle and syringe
Alcohol wipe

Vial

1. Check date on medication order and verify its accuracy by checking it against the doctor's order. Review 10 rights.
2. Check patient's record for any drug allergies.
3. Gather equipment.
4. Wash your hands.
5. Check label on the medication three times before administering it.
 - When taking container from shelf
 - Just before pouring
 - Before returning container or before discarding wrapper
6. Mix solution if necessary by rotating vial between palms of hands, not by shaking.
7. Remove protective metal cap and clean rubber cap with alcohol wipe, rubbing in a circular motion.
8. Remove the cap from the needle, and then draw up into the syringe an amount of air equal to volume of medication to be withdrawn.
9. Insert needle into vial through center of rubber cap, maintaining sterility of the needle.
10. Inject air into vial.
11. Invert vial and hold at eye level while withdrawing the correct dosage of the drug into the syringe.
12. Expel air bubbles into vial.
13. Withdraw the needle from the vial, and replace the cap over the needle to maintain sterility.
DO NOT use passive scoop technique with a sterile needle.
14. Properly dispose of medication vial.

Ampules

Perform Steps 1–5 as listed for vials, then:

1. Flick upper stem of ampule several times with fingernail. Make certain all medication is out of the ampule stem.
2. Place an alcohol swab on the far side of the ampule neck and break off the top by bending the top toward you with quick snap. This allows the glass to break away from you and anyone else.
3. Assemble syringe and needle if necessary.
4. Remove cap from needle, insert needle into the ampule, and withdraw amount of drug required. Do not inject air into ampule. If a single-dose ampule, hold slightly on its side to obtain all of the medication.
5. Replace cap over needle.
6. Dispose of ampule in proper container.

ADMINISTRATION OF INTRAMUSCULAR INJECTION (SEE LEARNING GUIDE)

Equipment: Prescribed medication
Medication order
Appropriate size sterile syringe
Appropriate size needle
Alcohol swabs

Variation on Intramuscular Injection: Z TRACK - PROCEDURE

1. Used for medications that stain or irritate subcutaneous epidermis/dermis (example: iron).
2. Select appropriate gauge and length for a deep intramuscular injection.
3. Change needle between withdrawing fluid from vial and before administering (injecting).
4. Add 0.2-cc air bubble before administering. Invert syringe so bubble will follow medication out of syringe.
5. Injection site is ventrogluteal or dorsal gluteal. Retract or pull back subcutaneous tissue before injecting.
6. Pull back subcutaneous tissue to one side before inserting needle.
7. Insert deep IM at 90°.
8. Inject medication slowly.
9. Withdraw needle.
10. Allow subcutaneous tissue to move back into place by *releasing retraction on tissue*.
11. **Do not** massage muscle.

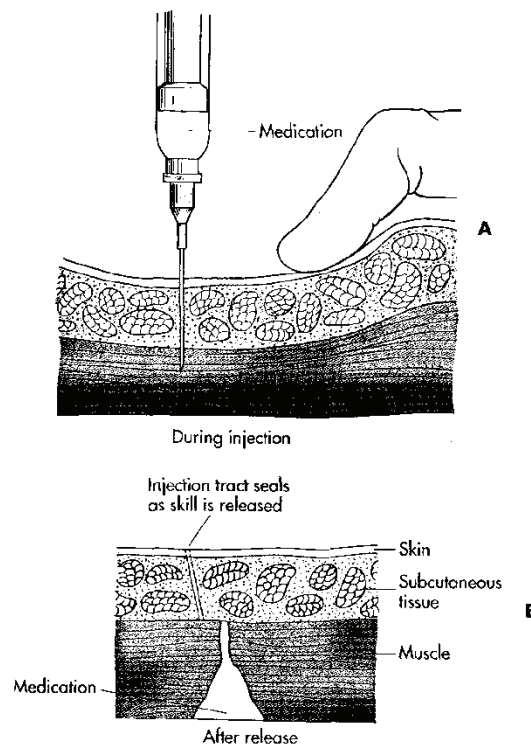


Figure A, Pull on overlying skin during IM injection moves tissue to prevent later tracking. B, The Z-track left after injection prevents the deposit of medication through sensitive tissue.

ADMINISTRATION OF INTRADERMAL INJECTION

Technique

1. Select 1-cc or tuberculin syringe; gauge should be 25 or finer and length 5/8".
2. Draw up ordered medication.
3. Stretch the skin taut with one hand.
4. Keep bevel up.
5. Insert so that lumen is just under the skin, about 0.5 cm.
6. Inject medication. Should see a raised area appear forming a wheal with some blanching.

Intradermal PPD Test

TST reaction of $>$ or $=$ 5 mm is interpreted as positive in the following groups:

- HIV-infected
- Recent contact of TB case
- Persons with fibrotic changes on chest CXR with old healed TB
- Patients with organ transplants or other immunosuppressed patients (receiving the equivalent of $>$ or $=$ 15 mg/day of prednisone for $> =$ 1 month)
- ≥ 10 mm is positive in persons who do not meet the preceding criteria but who have other risk factors for TB. These include:
 - Recent arrivals from high-prevalence countries
 - Injection drug users
 - Residents and employees of high-risk congregate settings (prisons, nursing homes, shelters, hospitals)
 - Mycobacteriology lab personnel
 - Persons with medical conditions that place them at high risk (diabetes, end stage renal disease, low body weight)
 - Children under 4 years
 - Children and adolescents exposed to adults in high-risk categories
 - >15 mm is positive in persons with no known risk factors who, except for certain screening programs required by local law or regulation, would otherwise not be tested
 - May be certain types of health care workers depending on where they work

CHECKLIST 31.1: ADMINISTERING AN INTRAMUSCULAR INJECTION

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR ADMINISTERING AN INTRAMUSCULAR INJECTION	
STEP	SCORE
GETTING READY	
1. Check the medication order and verify its accuracy by checking it against the doctor's order.	
2. Check the patient's record for any drug allergies.	
3. Gather equipment.	
4. Perform hand hygiene.	
5. Cross-check the patient's identity with medication order.	
6. Check the label on the medication three times before administering it.	
7. Prepare the vial and syringe.	
8. Add appropriate amount of air into syringe.	
9. Prepare the correct amount of medication in the syringe.	
10. Provide for privacy; position and drape the patient.	
PROCEDURE	
11. Select appropriate injection site using landmarks.	
12. Cleanse injection site if skin is soiled.	
13. Remove needle cover.	
14. Grasp or spread skin with non-dominant hand depending on the amount of muscle present.	
15. Quickly insert the needle at 90° using a smooth darting motion.	
16. Pull back on the plunger slightly to check for blood.	
17. If none, inject medication slowly. If blood return, remove needle and re-start procedure with a new needle and syringe.	
18. Withdraw needle and massage area.	
19. Discard needle in sharps container.	
20. Record medication given, site used, dosage, and time.	
21. Perform hand hygiene.	
22. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM INTRAMUSCULAR INJECTIONS

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 31.2: ADMINISTERING NASAL INSTALLATION

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR ADMINISTERING NASAL INSTALLATION	
STEP	SCORE
GETTING READY	
1. Greet the patient and relatives by name and introduce yourself respectfully.	
2. Verify the patient's identity by checking name tag and compare with the patient's chart.	
3. Explain to the patient or relatives clearly the purpose of administering nasal installation, and answer honestly any question that the patient or relatives ask.	
4. Verify order: Check patient's chart for physician's order.	
5. Assemble all needed materials on a tray and place it at the bedside.	
6. Ensure patient privacy.	
7. Explain procedure: Patient should expect to feel burning of stinging of the mucosa, or choking sensation as medication trickles into the throat.	
PROCEDURE	
8. Place the patient in a supine position and position head properly.	
9. Perform hand hygiene.	
10. Put on disposable gloves.	
11. Inspect the condition of the nose or sinuses, and palpate sinuses for tenderness.	
12. Instruct the patient to blow nose unless contraindicated, for example, nose bleeding, administering of nasal drop.	
13. Instruct the patient to breathe through the mouth.	
14. Hold dropper 1 cm (1/2 inch) above nasal aid and instill prescribed number of drops.	
15. Keep the patient in supine position for 5 minutes.	
16. Offer facial tissue to blot running nose but caution against blowing nose for several minutes.	
17. Assist the patient to get comfortable after drug is absorbed.	
18. Properly discard all used materials.	
19. Properly remove and dispose of gloves.	
20. Wash hand after the removal of gloves.	
21. Record and report relevant data.	

CHECKLIST FOR ADMINISTERING NASAL INSTALLATION	
STEP	SCORE
22. Observe for 15–30 minutes.	
23. Report all findings to the In-Charge.	
24. Perform hand hygiene.	
25. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO ADMINISTER NASAL INSTALLATION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (*in case of need to remediate or other*):

CHECKLIST 31.3: ADMINISTERING ORAL MEDICATIONS

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR ADMINISTERING ORAL MEDICATIONS	
STEP	SCORE
GETTING READY	
1. Check the medication order and verify its accuracy by checking it against the doctor's order. Check for the 5 rights: right name, right drug, right dosage, right time for administration and right route of administration.	
2. Check the patient's record for any drug allergies.	
3. Gather equipment.	
4. Perform hand hygiene.	
5. Check the label on the medication three times before administering it.	
PROCEDURE	
6. Prepare the correct amount of medication.	
7. Confirm the patient's identity.	
8. Assist the patient to a sitting position, or if not possible, to a lateral position.	
9. Give the patient the medication and an appropriate liquid as needed. (If SL, ask patient to lift tongue and place under the tongue and avoid giving water until dissolved.)	
10. Record medication given, dosage, time, and any complaints of patient and signature of nurse or physician.	
11. Perform hand hygiene.	
12. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ QUALIFIED ☐ NOT QUALIFIED TO ADMINISTER ORAL MEDICATIONS

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

CHECKLIST 31.4: ESTABLISHING A PERIPHERAL INTRAVENOUS LINE

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR ESTABLISHING A PERIPHERAL INTRAVENOUS LINE	
STEP	SCORE
GETTING READY	
1. Read the order or protocol, calculating the rate if not provided for you.	
2. Gather necessary equipment and supplies.	
3. Tell the patient what is going to be done and encourage him/her to ask questions.	
4. Listen to what he/she has to say.	
5. Perform hand hygiene with soap and water and dry with a clean, dry cloth (or air dry).	
PROCEDURE	
6. Prepare the solution to be infused, ensuring that the entire infusion set is filled with fluid and that there is no air in the infusion set: <ul style="list-style-type: none"> If using a butterfly set, ensure that the set is filled with IV fluid. 	
7. Put on clean examination gloves.	
8. Clean the skin over the vein using a swab or cotton-wool ball soaked in antiseptic solution and allow to dry.	
9. Insert the needle through the skin at a 15–30 degree angle using a threading motion, with the bevel of the needle facing upward: <ul style="list-style-type: none"> If using a butterfly set, a small amount of blood will flush back into the tubing when the vein is punctured, indicating that the needle is inserted far enough. 	
10. If using a cannula: <ul style="list-style-type: none"> When blood fills the hub of the cannula, withdraw the needle partially while continuing to push the cannula in. 	
11. When the hub of the cannula reaches the skin at the puncture site, withdraw the needle completely.	
12. Dispose of the needle in a puncture-resistant sharps container.	
13. Connect the infusion set to the cannula or butterfly set: <ul style="list-style-type: none"> Ensure that there are no air bubbles in the system. Infuse fluid into the vein for a few seconds to make sure the vein has been successfully cannulated. 	

CHECKLIST FOR ESTABLISHING A PERIPHERAL INTRAVENOUS LINE	
STEP	SCORE
14. If swelling develops around the site of infusion, remove the needle and repeat the procedure using a different vein.	
15. If using a vein in the hand, arm, foot, or leg, stabilize the limb with a splint to minimize movement.	
16. Secure the cannula or butterfly set in position using strips of adhesive strapping or thin paper tape: <ul style="list-style-type: none"> If tincture of benzoin is available, apply this to the skin before applying the adhesive strapping. 	
17. Monitor the infusion site every hour: <ul style="list-style-type: none"> If redness or swelling is seen at any time, stop the infusion, remove the needle, and establish a new IV line in a different vein. 	
18. Check the rate and volume of fluid given every hour.	
19. Record all findings.	
POST-PROCEDURE STEPS	
20. Place any blood-contaminated items (swabs or cotton-wool balls) in a plastic bag or leak-proof, covered waste container.	
21. Decontaminate instruments by placing them in a plastic container filled with 0.5% chlorine solution for 10 minutes.	
22. Perform hand hygiene.	
23. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO ESTABLISH A PERIPHERAL INTRAVENOUS LINE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (*in case of need to remediate or other*):

CHECKLIST 31.5: ESTABLISHING TWO IV LINES

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR ESTABLISHING TWO IV LINES	
STEP	SCORE
GETTING READY	
1. Greet the patient and relatives by name and introduce yourself respectfully	
2. Verify the patient's identity by checking name tag and compare with the patient's chart.	
3. Explain to the patient or relatives clearly the purpose of establishing two lines, and answer honestly any question that the patient or relatives ask.	
4. Verify order: Check the patient's chart for physician's order.	
5. Assemble all needed materials on a tray and place it at the bedside.	
6. Ensure the patient's privacy.	
7. Explain procedure.	
PROCEDURE	
8. Place the patient in comfortable position.	
9. Perform hand hygiene.	
10. Put on disposable gloves.	
11. Assess IV site for inflammation or and possible infiltration/ scar due to previous infusion.	
12. Properly discard of all used materials.	
13. Properly remove and dispose of gloves.	
14. Report all findings to Charge Nurse.	
15. Record and report relevant data.	
16. Perform hand hygiene.	
17. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO ESTABLISH TWO IV LINES

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

31.5.1: RISKS OF INTRAVENOUS THERAPY

Infection

Any break in the skin carries a risk of infection. Although IV insertion is an aseptic procedure, skin-dwelling organisms such as Coagulase-negative staphylococcus or Candida albicans may enter through the insertion site around the catheter, or bacteria may be accidentally introduced inside the catheter from contaminated equipment. Moisture introduced to unprotected IV sites through washing or bathing substantially increases the infection risks.

Infection of IV sites is usually local, causing easily visible swelling, redness, and fever. If bacteria do not remain in one area but spread through the bloodstream, the infection is called septicemia and can be rapid and life-threatening. An infected central IV poses a higher risk of septicemia, as it can deliver bacteria directly into the central circulation.

Phlebitis

Phlebitis is irritation of a vein that may be caused by infection, the mere presence of a foreign body (the IV catheter) or the fluids or medication being given. Symptoms are warmth, swelling, pain, and redness around the vein. The IV device must be removed and if necessary re-inserted into another extremity.

Due to frequent injections and recurring phlebitis, scar tissue can build up along the vein. The peripheral veins of intravenous drug addicts, and of cancer patients undergoing chemotherapy, become sclerotic and difficult to access over time, sometimes forming a hard “venous cord.”

Infiltration

Infiltration occurs when an IV fluid accidentally enters the surrounding tissue rather than the vein. It is characterized by coolness and pallor to the skin as well as localized swelling or edema. It is usually not painful. It is treated by removing the intravenous access device and elevating the affected limb so that the collected fluids can drain away. Infiltration is one of the most common adverse effects of IV therapy and is usually not serious unless the infiltrated fluid is a medication damaging to the surrounding tissue, in which case the incident is known as extravasation.

Fluid Overload

This occurs when fluids are given at a higher rate or in a larger volume than the system can absorb or excrete. Possible consequences include hypertension, heart failure, and pulmonary edema.

Electrolyte Imbalance

Administering a too-dilute or too-concentrated solution can disrupt the patient's balance of sodium, potassium, magnesium, and other electrolytes. Hospital patients usually receive blood tests to monitor these levels.

Embolism

A blood clot or other solid mass, as well as an air bubble, can be delivered into the circulation through an IV and end up blocking a vessel; this is called embolism. Peripheral IVs have a low risk of embolism, since large solid masses cannot travel through a narrow catheter, and it is nearly impossible to inject air through a peripheral IV at a dangerous rate. The risk is greater with a central IV.

Air bubbles of less than 30 milliliters are thought to dissolve into the circulation harmlessly. Small volumes do not result in readily detectable symptoms, but ongoing studies hypothesize that these "micro-bubbles" may have some adverse effects. A larger amount of air, if delivered all at once, can cause life-threatening damage to pulmonary circulation, or, if extremely large (3–8 milliliters per kilogram of body weight), can stop the heart.

One reason veins are preferred over arteries for intravascular administration is because the flow will pass through the lungs before passing through the body. Air bubbles can leave the blood through the lungs. A patient with a heart defect causing a right-to-left shunt is vulnerable to embolism from smaller amounts of air. Fatality by air embolism is vanishingly rare, in part because it is also difficult to diagnose.

Extravasation

Extravasation is the accidental administration of IV infused medicinal drugs into the surrounding tissue which are caustic to these tissues, either by leakage (e.g., because of brittle veins in very elderly patients), or directly (e.g., because the needle has punctured the vein and the infusion goes directly into the arm tissue). This occurs more frequently with chemotherapeutic agents and people who have tuberculosis.

31.6: INTRAVENOUS INTRODUCTION

IV LAB

Equipment Needed

Check background to determine which stations are in which lab.

Basic IV Set-Up

- 2 Transparencies of a hand with angiocath, 7-inch extension, and needleless connector attached with Duoderm
- 4 Minidrop IV sets
- 4 Macrodrop IV sets
- 2 7-inch extension sets with needleless connector
- 4 Twin site extension sets with needleless connector
- 4 Bags of 1-liter 0.9 NS
- 2 Rolls of 1-inch tape
- 1 Box of gloves (may be at bedside)
- Alcohol wipes
- Several emesis basins to hold supplies and caps
- 1 Procedure list for IV set-up AND sample IV dosage calculation problems

Heparin/Saline Lock *(May be combined with another station; check schedule)*

- 4 Rolled-up ABD pads each with an inserted angiocath, locked with 7-inch extension and needleless connector
- 4 Vials of 30 cc saline
- Saline flush in pre-filled syringes (1 per student)
- Single-dose heparin flush vials (1 per student)
- 1 Multi-dose vial of heparin lock flush solution
- Heparin flush solution in tubex/carpujet cartridges (1 per student)
- 4 Multi-dose vial access spikes
- 2 Tubexes/carpujet holders
- 1-cc syringes (2 per student)
- 3-cc syringes (1 per 3 students)
- 22-g needles (1 per student)
- Alcohol pads (2 per student)
- Needle box
- Procedure list for heparin/saline lock station

Procedure

Piggyback Medications

- Main line set up that has a bag connected to a macro IV tubing, and a twin clavé Y site extension set
- 1 Mini-bottle connected to mainline IV system via Y-injection site on twin extension tubing (either macro- or micro-drip tubing)
- 1 Mini-bottle connected to mainline IV system via stopcock (macro- or micro-drip tubing)
- 2 Extra mini-bags of solution
- 2 Extra stopcocks with clavé connector caps for the stopcock ports
- Several 3-cc syringes
- 2 or 3 Bottles of NS that have clavé vial adaptors to flush if drug not compatible
- 1 Extra bag of IV fluid

Alcohol wipes
Basin to run fluid into with incontinent pad under it
1 Procedure list for hanging mini-bags

IV Push Station

3 Bottles heparin 10u/cc flush bottles or other bottles labeled as heparin flush
4 Multi-vial dose bottles of sterile NS to draw up flushes with the adaptors to stick in the multi-vial dose bottles so they can be accessed with the needleless system syringes
3-cc syringes with 22-g 1" needles to draw up the medication to push (1 per student)
5-cc syringes to draw up 4 cc at a time (2 cc for pre-flush and 2 cc post-flush) (1 per student)
Alcohol pads (2 per student)
Procedure for IV push meds
JHH table of drugs that can be pushed by IV and the prescribed rate

Objective: The student will demonstrate competence in the setup of intravenous fluid by accurately completing elements listed below. (See IV Start Learning Guide.)

Equipment:

IV bag
IV pole
Administration set
Tape to time tape, and date tubing
Note: IV bag may be spiked first with administration set tubing and then the twin Y extension set and the 7-inch extension set is added. Complete setup is then primed.

IV SITE CARE

Site care varies from hospital to hospital but *is always a sterile technique*. Site care includes observation of IV site for redness, edema, purulent drainage, evidence of thrombophlebitis, infiltration, or leakage of fluid at site. *If any of these are observed, report immediately and prepare to discontinue IV*. In many hospitals, site care is incorporated with site change every 72 hours and thus the site dressing is only changed if necessary.

Equipment:

Gloves
½-Inch tape
1-Inch tape
Clear cover
Betadine or alcohol as necessary**

1. After new IV site is found and prepped with antiseptic, needle is inserted and IV started.
2. The angio is secured by placing the sticky part of ½ inch tape under the angio, over the wings, and on the skin at either side of insertion site.
3. Once angio is secure, apply sticky side of sorbaview over angio and insertion site.
4. Loop tubing and tape with two strips of 1-inch tape.
5. Date and time dressing.

*Betadine or alcohol used only if site must be cleaned due to leaking blood, etc.

Gauze Dressing

Equipment:

Sterile 2 x 2 gauze

½-Inch tape

1-Inch tape

2-Inch tape

Alcohol and/or betadine swab

Antimicrobial ointment

Gloves

Procedure:

1. Gather equipment.
2. Wash your hands.
3. Carefully remove old dressing, making certain to keep IV needle well-secured.
4. Using circular motion, clean site with alcohol or betadine.
5. Using criss-cross technique, secure hub with ½-inch tape. *Make certain not to place tape directly over insertion site.*
6. Apply antimicrobial ointment to insertion site.
7. Cover with sterile 2 x 2 gauze.
8. Cover with 2-inch tape.
9. Loop IV once and secure with several strips of 1-inch tape.

Discontinuing an Intravenous Infusion

Equipment:

Tape

2 x 2 or Band-Aid

Clean gloves

Procedure:

1. Gather equipment.
2. Wash your hands.
3. Close flow clamp of IV bottle.
4. Remove tape and dressing.
5. Remove needle *quickly and smoothly*.
6. Cover site with 2 x 2 and apply pressure to site until bleeding has ceased.
7. Secure with tape.
8. Properly dispose of IV and needle.

Changing an IV to a Saline Lock

1. Check doctor's order.
2. Wash hands.
3. Turn off flow clamp to IV.
4. Disconnect administration set from Clave connector.
5. Flush extension tubing with 2–3 cc of 1:10 U heparin or 2–3 cc NS by inserting male end of syringe into silicone seal.
6. Tape extension tubing to extremity.

Accessing a Multi-dose Vial with a Needleless System

1. Remove cap on multi-dose vial.
2. Remove protective cover of spike of multi-dose vial access.
3. Push spike into rubber stopper of vial.
4. To access, swab silicone seal with alcohol.
5. Insert male distal end of syringe into Clave connector. Invert vial and withdraw medication. Add air first, if necessary.

PIGGYBACKING OF ADDITIONAL IV BOTTLE OR BAGS: (GRAVITY)

Through Y injection port of administration set

Used to administer two IVs at once or to administer mini-bag filled with ordered medication

1. Attach administration set to the mini-bag and prime tubing.
2. Swab silicon Y-port with alcohol.
3. Attach Luer lock of distal end of administration set into Clave injection site. Save the cap.
4. Push and twist until tight.
5. Open flow clamp.
6. Regulate mini-bottle to run over 30–60 minutes or over time recommended for infusion of the specific drug.
7. When IVPB has infused, close flow clamp of administration set.
8. Unscrew distal Luer lock from Clave.
9. Replace sterile cap on distal end of administration set.
10. Date and time tubing; change every 3–4 days.

Special Considerations

- If mini-bag cannot run concomitantly with main bag due to competition, raise mini-bag to above the level of main bag or if necessary, turn main bag off.
- If mini-bag cannot run concomitantly with main bag due to incompatibility, turn off main bag, flush line with 3–5cc NS, run mini-bag, flush line again with NS, and start main line IV.

ADMINISTRATION OF IV PUSH MEDICATIONS

Purpose: To assure prompt onset of drug action.

Prior to Administration

- Check doctor's order.
- Consult an IV push reference for directions relative to:
 - Permissible drugs/actions
 - Compatibility
 - Safe dosage
 - Dilution
 - Rate of administration
 - Specific monitoring requirements:
 - Vital signs
 - EKG
 - Mental status
 - Pain
- Label syringe with drug name and dose.

- Check the patient's ID and allergies.
- Assure medication is compatible with IV fluid and/or other IV medications. (If not compatible, obtain NS flush and administer before and after IV push medication.)
- Assure patency of IV.

Administration via Existing IV Fluid

- Select port closest to the IV insertion site and clean port with alcohol swab.
- Attach hub of syringe to port.
- Pinch off tubing proximal to port.
- Push in medication incrementally according to drug reference recommendation.
- After pushing each increment of medication, release tubing and allow existing IV fluid to advance medication through tubing.
- If medication is NOT compatible with IV fluid:
 - Turn off IV.
 - Flush with approximately 2 cc NS.
 - Push medication at prescribed rate.
 - Flush with NS at medication rate.
 - Turn on IV.

Administration via Saline Lock (SAS)

- Flush with NS and determine patency of site.
- Push medication at prescribed rate.
- Flush with NS at medication rate.

Administration via Heparin Lock (SASH)

- Flush with NS and determine patency of site
- Administer medication at prescribed rate
- Flush with NS at medication rate.
- Flush with approximately 2 cc of dilute heparin (10 u/cc).

CHECKLIST 31.7: OPHTHALMIC MEDICATION ADMINISTRATION

(To be completed by the **Assessor**)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR OPHTHALMIC MEDICATION ADMINISTRATION	
STEP	SCORE
GETTING READY	
1. Verify physician's order or facility protocol.	
1. Read label to make sure the drug is intended for ophthalmic use.	
2. Check expiration date.	
3. Identify the patient by name (and, if in-patient, patient record number).	
4. Perform hand hygiene and put on gloves.	
5. Explain procedure to the patient.	
PROCEDURE	
6. Clean area around eye if necessary with sterile cotton ball or pad.	
7. Remove dropper/draw up dose for eye drops.	
8. Ask the patient to look up and away from you.	
9. With a steady hand, hold the medication dropper on the patient's forehead.	
10. Use fingers of the other hand to pull down the patient's lower eyelid.	
11. Instill the prescribed number of drops into the conjunctival sac (not onto the patient's eyeball).	
12. For ointment, squeeze a small ribbon of ointment along the conjunctival sac from the inner to outer eyelid without touching the ointment tube to the eyelid.	
13. Remove excess ointment with tissue.	
14. Have the patient lie back for a few minutes.	
15. Perform hand hygiene.	
16. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO ADMINISTER OPHTHALMIC MEDICATION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 31.8: OTIC MEDICATION ADMINISTRATION

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR LEARNING GUIDE: OTIC MEDICATION ADMINISTRATION	
STEP	SCORE
GETTING READY	
1. Verify physician's order or facility protocol.	
2. Check expiration date.	
3. Warm drops in basin of warm water.	
4. Identify the patient by name (and, if in-patient, by patient record number).	
5. Perform hand hygiene and put on gloves.	
6. Explain procedure to the patient.	
PROCEDURE	
7. Have the patient lie on his/her side with affected ear facing up.	
8. Straighten the patient's ear canal: <ul style="list-style-type: none"> For adult: pull auricle up and back (see A&P for ear anatomy). For child: pull auricle down and back. 	
9. With a penlight, examine ear for drainage and clean if necessary.	
10. Straighten again, and instill the ordered number of drops.	
11. Have patient stay on side for 5–10 minutes for absorption.	
12. Place cotton ball loosely in ear canal, as appropriate.	
13. Perform hand hygiene.	
14. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ QUALIFIED ☐ NOT QUALIFIED TO ADMINISTER OTIC MEDICATIONS

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

CHECKLIST 31.9: RECTAL MEDICATION ADMINISTRATION

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR RECTAL MEDICATION ADMINISTRATION	
STEP	SCORE
GETTING READY	
1. Greet the patient respectfully if just approaching him/her.	
2. Perform hand hygiene and put on gloves.	
3. Place the patient on left side with knee and thigh drawn and left arm along his/her back.	
4. Cover the patient with bedcovers, exposing buttocks only.	
5. Remove suppository from wrapper.	
PROCEDURE	
6. With non-dominant hand, lift upper buttock.	
7. Apply small amount of water-soluble lubricant.	
8. Ask the patient to take deep breaths and relax.	
9. With the dominant hand, insert tapered end of suppository into rectum with 1 finger, past the anal sphincter (about to the length of your finger).	
10. Ask patient to retain suppository as long as possible.	
11. Have bed pan available if necessary.	
12. Dispose of waste.	
13. Perform hand hygiene.	
14. Document procedure and/or findings. .	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO ADMINISTER RECTAL MEDICATIONS

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

CHECKLIST 31.10: RESPIRATORY MEDICATION ADMINISTRATION

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR RESPIRATORY MEDICATION ADMINISTRATION	
STEP	SCORE
GETTING READY	
1. Verify physician's order or facility protocol.	
2. Check expiration date.	
3. Identify the patient by name (and, if in-patient, patient record number).	
4. Greet the patient respectfully.	
5. Explain procedure to the patient.	
6. Perform hand hygiene and put on gloves.	
7. Gather the materials.	
8. Make sure that the patient is in a comfortable sitting position.	
9. Shake inhaler canister well.	
10. Remove cap, turn canister upside down, and insert stem into the small hold in the flattened portion of the mouthpiece.	
11. Ask patient to exhale, and then hold the inhaler about 2.5 cm in front of his/her open mouth (if held in the mouth, medicine will disperse to gums rather than shooting down his/her throat).	
12. Tell the patient to inhale slowly through the mouth and continue inhaling until the lungs feel full.	
13. As the patient begins to inhale, compress the drug canister into the plastic housing of the inhaler to release a metered dose of the drug.	
14. Tell the patient to hold his/her breath as long as he can, then to exhale slowly.	
15. Perform hand hygiene.	
16. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO ADMINISTER RESPIRATORY MEDICATION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (*in case of need to remediate or other*):

CHECKLIST 31.11: TRANSDERMAL MEDICATION ADMINISTRATION

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR TRANSDERMAL MEDICATION ADMINISTRATION	
STEP	SCORE
GETTING READY	
1. Verify physician's order or facility protocol.	
2. Check expiration date.	
3. Identify the patient by name (and if in-patient, the record number).	
4. Perform hand hygiene and put on gloves.	
5. Explain procedure to the patient.	
PROCEDURE	
6. Choose application site (most common are upper arm, chest, and upper back, behind ear). Rotate site if removing an old patch and applying a new one.	
7. Wash site with soap and warm water and dry thoroughly.	
8. Open the drug package and remove the patch.	
9. Remove backing layer.	
10. Apply to site (do not touch adhesive).	
11. Do not apply to areas of broken or irritated skin, because this will alter the release of the medication.	
12. Dispose of waste materials.	
13. Perform hand hygiene.	
14. Document procedure and/or findings.	
Total	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO ADMINISTER TRANSDERMAL MEDICATION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

32.1: DEPRESSION SCREEN PHQ-9

With patients you suspect are depressed, also do this **PHQ-9 Screen for helping to identify depression (modified to Liberian English by Tiya Health)**. However, you do not have to suspect depression to use this tool; patients may fill out this tool as a common practice while waiting to be seen, *depending on literacy level*. The nine items of the PHQ-9 are based directly on the nine diagnostic criteria for major depressive disorder in the DSM-IV (Diagnostic and Statistical Manual, Fourth Edition). Utilizing the PHQ-9 helps to track a patient's overall depression severity as well as the specific symptoms that are improving or not improving with treatment.

If the patient is unable to read form, explain to the patient, **“I am going to ask you some questions that will help us know how we can help you. When you answer, we would like you to think about ONLY the past TWO weeks, even if your problems have lasted for much longer.”**

Then ask the following questions: Since the past 2 weeks:	Never	Few Times	Plenty Times	Nearly Every Day
1. Have you been feeling not happy when you are doing things? OR Have you been feeling your heart can't be there to do anything?	0	1	2	3
2. Have you been feeling down-hearted, overloaded, or like you are having no hopes?	0	1	2	3
3. Have you had trouble falling asleep, staying asleep, or sleeping over-plus?	0	1	2	3
4. Have you been feeling weak or tired, or like you have little strength when working?	0	1	2	3
5. Do you sometimes feel like you can't eat? OR Do you sometimes eat over-plus?	0	1	2	3
6. Do you ever feel bad about yourself, or ashamed of your problems? OR Do you feel that nothing good will come out of you?	0	1	2	3
7. Do you sometimes only complete your work half-way because you are thinking plenty? OR Do you feel like your mind can't be there when doing your housework?	0	1	2	3
8. Have people noticed that you are moving and talking very slowly? [GIVE TIME TO ANSWER] Have they noticed the opposite—that you are too active, so that you are moving around without doing anything?	0	1	2	3
9. Do you sometimes think it is better that you die, or think of doing harm to yourself?	0	1	2	3
Add the scores from each question for Total Score: _____	=__	+__	+__	+__

Original source of PHQ-9: Spitzer R, Kroenke K, Williams J, et.al. with an educational grant from Pfizer, in PRIME MD TODAY, 1999. Copyright Pfizer, Inc. Tiya Health contributors to Liberian version: Danielle Alkov, Matt Burkey, Othello Davis, Moses Gramoe, Bent Grant, Katie Kentoffio, Patrick Lee, Tina Mouwan, Amisha Raja, Hemali Thakkar, and Kalisa Yesero.

Score interpretation: (Range: 0–27):

0–4 = No depression

5–14 = Possible depression requiring support and education—Treat if you have had some training, or refer to a Mental Health Clinician.

15+ = Very likely severe depression requiring medication, support, and education—it is best to refer this patient immediately to a Mental Health Clinician.

Also check how well the depressed patient can function, with the next short screen.

FUNCTIONAL IMPAIRMENT:

If the total PHQ-9 score ≥ 17 , and functional impairment also is definitely present, refer the patient to a mental health clinician for treatment.

Now ask: How hard have you found it to do some of your work, to do your housework, to take care of your children, or to go around your friends and family because of these problems?	Not Hard	Hard Small	Very Hard
Functional Impairment:	No	Small	Yes

32.2: MINI-MENTAL STATUS EXAMINATION

The Mini-Mental Status Examination offers a quick and simple way to quantify cognitive function and screen for cognitive loss. It tests the individual's orientation, attention, calculation, recall, and language and motor skills.

Each section of the test involves a related series of questions or commands. The individual receives one point for each correct answer.

To give the examination, seat the individual in a quiet, well-lit room. Ask him/her to listen carefully and to answer each question as accurately as he/she can.

Don't time the test, but score it right away. To score, add the number of correct responses. The individual can receive a maximum score of 30 points.

A score below 20 usually indicates cognitive impairment.

The Mini-Mental Status Examination

Name: _____

DOB: _____

Years of School: _____

Date of Exam: _____

	Correct	Incorrect	
Orientation to Time			
What is today's date?	<input type="checkbox"/>	<input type="checkbox"/>	
What is the month?	<input type="checkbox"/>	<input type="checkbox"/>	
What is the year?	<input type="checkbox"/>	<input type="checkbox"/>	
What is the day of the week today?	<input type="checkbox"/>	<input type="checkbox"/>	
What season is it?	<input type="checkbox"/>	<input type="checkbox"/>	
			Total: _____

Orientation to Place			
Whose home is this?	<input type="checkbox"/>	<input type="checkbox"/>	
What room is this?	<input type="checkbox"/>	<input type="checkbox"/>	
What city are we in?	<input type="checkbox"/>	<input type="checkbox"/>	
What county are we in?	<input type="checkbox"/>	<input type="checkbox"/>	
What state are we in?	<input type="checkbox"/>	<input type="checkbox"/>	
			Total: _____

Immediate Recall

Ask if you may test his/her memory. Then say "ball", "flag", "tree" clearly and slowly, about 1 second for each. After you have said all 3 words, ask him/her to repeat them—the first repetition determines the score (0–3):

Ball	<input type="checkbox"/>	<input type="checkbox"/>	
Flag	<input type="checkbox"/>	<input type="checkbox"/>	
Tree	<input type="checkbox"/>	<input type="checkbox"/>	
			Total: _____

Correct

Incorrect

Attention

A) Ask the individual to begin with 100 and count backwards by 7. Stop after 5 subtractions. Score the correct subtractions.

93

☐☐

86

☐☐

79

☐☐

72

☐☐

65

☐☐

Total: _____

B) Ask the individual to spell the word "WORLD" backwards. The score is the number of letters in correct position.

D

☐☐

L

☐☐

R

☐☐

O

☐☐

W

☐☐

Total: _____

Delayed Verbal Recall

Ask the individual to recall the 3 words you previously asked him/her to remember.

Ball

☐☐

Flag

☐☐

Tree

☐☐

Total: _____

Naming

Show the individual a wristwatch and ask him/her what it is. Repeat for pencil.

Watch

☐☐

Pencil

☐☐

Total: _____

Repetition

Ask the individual to repeat the following:

"No if, ands, or buts"

☐☐

Total: _____

Correct

Incorrect

3-Stage Command

Give the individual a plain piece of paper and say, "Take the paper in your hand, fold it in half, and put it on the floor."

Takes

☐☐

Folds

☐☐

Puts

☐☐

Total: _____

Reading

Hold up the card reading: "Close your eyes" so the individual can see it clearly.

Ask him/her to read it and do what it says. Score correctly only if the individual actually closes his/her eyes.

☐☐

Total: _____

Writing

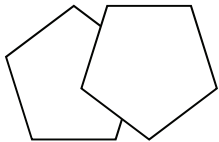
Give the individual a piece of paper and ask him/her to write a sentence. It is to be written spontaneously. It must contain a subject and verb and be sensible.

☐☐

Total: _____

Copying

Give the individual a piece of paper and ask him/her to copy a design of two intersecting shapes. One point is awarded for correctly copying the shapes. All angles on both figures must be present, and the figures must have one overlapping angle.

☐☐

Total: _____

TOTAL SCORE: _____

32.3 TRAUMA SCREENING QUESTIONNAIRE (TSQ)

Trauma Screening Questionnaire (TSQ) for helping identify PTSD:

Ask the following 10 questions. A “yes” response to 6 or more indicates a very strong possibility of the client having PTSD.

(It is best to wait at least 3 weeks after the event before administering the TSQ.)

In the last 2 weeks, have you had (or have you been):	YES, at least twice in the past week	NO
1. Upsetting thoughts or memories about the event that have come into your mind against your will?		
2. Upsetting dreams about the event?		
3. Acting or feeling as if the event were happening again?		
4. Feeling upset by things that remind you of the event?		
5. Body reactions (such as fast heartbeat, stomach churning, sweating, or feeling dizzy) when reminded of the event?		
6. Difficulty falling asleep or staying asleep?		
7. Irritability, or outbursts of anger?		
8. Difficulty concentrating?		
9. Feeling much more aware of possible dangers to yourself and others?		
10. Being jumpy or startled at something unexpected?		

Original Source: Brewin CR et.al. 2002. Brief screening instrument for post-traumatic stress disorder. *British Journal of Psychiatry* 181: 158–162.

CHECKLIST 33: NASOGASTRIC TUBE INSERTION

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR NASOGASTRIC TUBE INSERTION	
STEP	SCORE
GETTING READY	
1. Greet the patient and relatives by name and introduce yourself respectfully.	
2. Verify the patient's identity by checking name tag and compare with patient's chart.	
3. Verify order: Check the patient's chart for physician's order.	
4. Assemble all needed materials on a tray.	
5. Perform hand hygiene and put on gloves.	
PROCEDURE	
6. Check the nasal for patency.	
7. Position the client (lay the client in supine position and flex neck).	
8. Cut adhesive tape.	
9. Determine how far to insert the tube (beginning from the ear lobe to the tip of the nose and down to the typhus process).	
10. Mark the end of the tube at the typhus process with adhesive tape.	
11. Ensure that the patient is still in a supine position.	
12. Tilt the patient's head at 45°.	
13. Lubricate the tip of the NG tube with K-Y jelly.	
14. Gently and skillfully insert NG tube up to the mark, while asking the client to swallow.	
15. Use bulb syringe to aspirate gastric content.	
16. Place tip of NG tube under the water within the kidney basin, observe for the absent of bubbles.	
17. Collect air in a 5-cc syringe and infuse it via NG tube while listening over epigastria with stethoscope.	
18. Properly anchor the tube with adhesive tape around the nose.	
19. Secure NG tube on the fore-head with adhesive tape.	
20. Properly discard all used materials.	
21. Properly remove and dispose of gloves.	
22. Make plan for continuing care of NG tube.	
23. Report all findings to Charge Nurse.	

CHECKLIST FOR NASOGASTRIC TUBE INSERTION	
STEP	SCORE
24. Perform hand hygiene.	
25. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO INSERT A NASOGASTRIC TUBE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 33.1: NASOGASTRIC (NG) TUBE GAVAGE

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR NASOGASTRIC GAVAGE PROCEDURE	
STEP	SCORE
GETTING READY	
1. Greet the patient and relatives by name and introduce yourself respectfully.	
2. Verify the patient's identity by checking name tag and compare with the client's chart.	
3. Clearly explain to the patient or relatives the purpose of gastric gavage, and answer honestly any question that the patient or relatives ask.	
4. Verify order: Check the patient's chart for physician's order.	
5. Assemble all needed materials on a tray.	
6. Assess tube patency.	
7. Ensure food quality.	
PROCEDURE	
8. Perform hand hygiene.	
9. Put on gloves.	
10. Remove bulb syringe from calibrated syringe.	
11. Irrigate the syringe.	
12. Place the syringe at the height of the IV pole.	
13. Pull the food content into the syringe with the require measurement.	
14. Clamp the NG tube.	
15. Recollect food content/repeat feeding procedure PRN.	
16. Clamp tube.	
17. Collect fluid and rinse NG tube.	
18. Close the tubing.	
19. Place the patient in a comfortable position.	
20. Properly discard all used materials.	
21. Properly remove and dispose of gloves.	
22. Monitor patient for possible problem.	
23. Report all findings to Charge Nurse.	

CHECKLIST 33.2: NASOGASTRIC (NG) TUBE GAVAGE (FOR BABIES AND CHILDREN)

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR NASOGASTRIC GAVAGE PROCEDURE (For Babies and Children)	
STEP	SCORE
GETTING READY	
1. Greet the patient and caregivers by name and introduce yourself respectfully.	
2. Verify the patient's identity by checking name tag and compare with the client's chart.	
3. Clearly explain to the patient and caregivers the purpose of gastric gavage, and answer honestly any question that the patient or relatives ask.	
4. Verify order: Check the patient's chart for physician's order.	
5. Assemble all needed materials on a tray.	
6. Ensure food/formula quality.	
PROCEDURE	
7. Perform hand hygiene.	
8. Put on gloves.	
9. Check for proper NG placement: <ul style="list-style-type: none"> a. Connect syringe to NG tubing after removing cap/plug. b. Place stethoscope over mid-left abdomen and gently push in 5–10 cc of air with syringe. c. Listen with stethoscope and identify sounds heard with proper placement. 	
10. Aspirate stomach contents by pulling plunger back.	
11. Measure stomach contents and return to stomach.	
12. Subtract from feeding if less than 10% of feeding (especially for babies).	
13. If volume is more than 50% of feeding, hold feeding and inform prescriber (especially for babies).	
14. Clamp/pinch NG tubing.	
15. Attach syringe without plunger to NG tube.	
16. Pour feeding into syringe, filling to almost full (90%).	
17. Open clamp on NG tubing, allowing feeding to run in slowly. (The higher the syringe is held, the faster the feeding will flow; so it will not go too fast, hold the syringe at an appropriate level. Babies or young children may suck on a gloved finger or pacifier.)	
18. Add more food/formula when liquid is at 5cc mark. Continue to add until feeding is completed as ordered.	

CHECKLIST FOR NASOGASTRIC GAVAGE PROCEDURE (For Babies and Children)	
STEP	SCORE
19. Flush NG tube with not more than 5 ml of water.	
20. Pinch or clamp NG tubing. Disconnect syringe.	
21. Clamp and/or cap NG tube.	
22. Make sure NG tube is secured.	
23. Keep the child in feeding position for at least 30 minutes after completing feeding.	
24. Clean and store syringe.	
25. Document feeding and observations in log.	
26. Report any problems.	
27. Perform hand hygiene.	
28. Document procedure and/or findings.	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM GASTRIC GAVAGE PROCEDURE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

34: NATIONAL MALARIA PROTOCOL FOR ADMINISTRATION OF QUININE FOR MALARIA

A. Protocol for intramuscular administration of quinine

*There is a recent FDA warning on **off-label** use of quinine like for **leg cramps**. Quinine should be used only for indicated and approved uses.*

Quinine for intramuscular injection in children should be diluted as follows: To quinine dihydrochloride (2 mL) – 600 mg/2 mL:

- Add 8 mL of NaCl (0.9%) solution.
- This gives a solution of 10 mL.
- After this dilution, each mL of this mixture is equivalent to 60 mg of quinine .
- You can calculate the dose using 10–15 mg/kg and administer up to two times per day on the anterior thigh of the patient (not on the buttocks).

QUANTITY	
0.5 cc	30 mg
1.0 cc	60 mg
1.5 cc	90 mg
2.0 cc	120 mg
2.5 cc	150 mg
3.0 cc	180 mg
3.5 cc	210 mg
4.0 cc	240 mg
4.5 cc	270 mg
5.0 cc	300 mg
5.5 cc	330 mg
6.0 cc	360 mg
6.5 cc	390 mg
7.0 cc	420 mg
7.5 cc	450 mg
8.0 cc	480 mg
8.5 cc	510 mg
9.0 cc	540 mg
9.5 cc	570 mg
10 cc	600 mg

B. Protocol for intravenous administration of quinine for malaria

To administer quinine intravenously for children, the following should be done:

- Calculate the total dose of quinine di-hydrochloride (15 mg/kg/day) to be administered two times a day.
- Calculate the quantity of dextrose in water (D5W-10-15 ml/kg) to be used for infusion.
- Add the appropriate dose of quinine calculated to the quantity of dextrose calculated.
- Allow the infusion to run for 4 hours (calculate the number of drops per minute) and repeat the same protocol every 12 hours.
- Give dextrose 50% 5–20 mL IV before each quinine infusion.
- Administer three courses of quinine infusion.
- After the last quinine infusion, change to either IM or oral quinine for the complete the 7-day course of treatment.

TREATMENT FOR UNCOMPLICATED MALARIA WITH AMODIAQUINE + ARTESUNATE (Confirmed by rapid diagnostic test and/or microscopy)

Weight (kg)	Blister Pack						Other Formulations Available								
	Artesunate** 50 mg tabs			Amodiaquine* 153 mg salt base			Artesunate** 100 mg tabs			Artesunate** 200 mg tabs			Amodiaquine* 200 mg salt base		
	Day 1	Day 2	Day 3	Day 1	Day 2	Day 3	Day 1	Day 2	Day 3	Day 1	Day 2	Day 3	Day 1	Day 2	Day 3
5-7	½	½	½	¼	¼	¼									
8-10	½	½	½	½	½	½									
11-13	1	1	1	¾	¾	¾	½	½	½	¼	¼	¼	½	½	½
14-16	1	1	1	1	1	1	½	½	½	¼	¼	¼	¾	¾	¾
17-19	1.5	1.5	1.5	1	1	1	¾	¾	¾	¼	¼	¼	¾	¾	¾
20-22	1 ¾	1 ¾	1 ¾	1 ¼	1 ¼	1 ¼	¾	¾	¾	½	½	½	1	1	1
23-25	2	2	2	1.5	1.5	1.5	1	1	1	½	½	½	1	1	1
26-28	2	2	2	1.5	1.5	1.5	1	1	1	½	½	½	1	1	1
29-31	2.5	2.5	2.5	2	2	2	1	1	1	½	½	½	1.5	1.5	1.5
32-34	2 ¾	2 ¾	2 ¾	2	2	2	1 ¼	1 ¼	1 ¼	¾	¾	¾	1 ¾	1 ¾	1 ¾
35-37	3	3	3	2.5	2.5	2.5	1.5	1.5	1.5	¾	¾	¾	1 ¾	1 ¾	1 ¾
38-40	3	3	3	2.5	2.5	2.5	1.5	1.5	1.5	¾	¾	¾	2	2	2
41-43	3.5	3.5	3.5	2 ¾	2 ¾	2 ¾	1 ¾	1 ¾	1 ¾	¾	¾	¾	2	2	2
44-46	3.5	3.5	3.5	3	3	3	1 ¾	1 ¾	1 ¾	1	1	1	2 ¼	2 ¼	2 ¼
47-49	3 ¾	3 ¾	3 ¾	3	3	3	2	2	2	1	1	1	2.5	2.5	2.5
50-52	4	4	4	3 ¼	3 ¼	3 ¼	2	2	2	1	1	1	2.5	2.5	2.5
53-55	4	4	4	3.5	3.5	3.5	2	2	2	1	1	1	2 ¾	2 ¾	2 ¾
56-58	4	4	4	3 ¾	3 ¾	3 ¾	2	2	2	1	1	1	3	3	3
59 and above	4	4	4	4	4	4	2	2	2	1	1	1	3	3	3

* Amodiaquine dosage is 10 mg/kg/day for 3 days + **Artesunate dosage is 4 mg/kg/day for 3 days.

Contraindications: pregnant women in first trimester and children weighing less than 5 kg.

Side Effects: Pruritus, nausea, and vomiting. These side effects should be explained to patients with reassurance that they are normal, but that the drugs are still working to get rid of the malaria parasites.


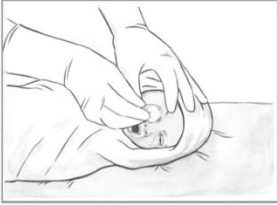

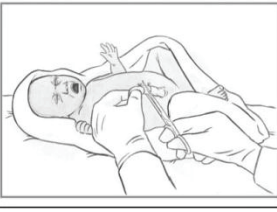


35: NEWBORN CARE




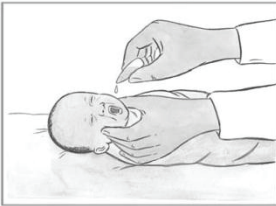

USAID
FROM THE AMERICAN PEOPLE

IMMEDIATE CARE OF THE NEWBORNS: A JOB AID FOR HEALTH CARE PROVIDERS.




STEP 1	<p>Dry and Warm the baby:</p> <ul style="list-style-type: none"> • Dry the baby vigorously with a clean, dry towel, taking care of head, axilla and groin and determines whether the baby is breathing. • Wipe eyes with clean dry cloth or gauze • Discard the wet towel and wrap the baby including the head quickly in another warm, dry cloth to keep him warm. 	 
STEP 2	<p style="text-align: center;">Assess the baby's breathing while drying:</p> <div style="display: flex; justify-content: space-around;"> <div> <p>If the baby cries or breathes normally proceed to Step 3, below.</p> </div> <div> <p>If the baby is not breathing, gasping or breathing slowly (< 30 breaths/minute) quickly clamp, tie and cut the cord, proceed to Resuscitation.</p> </div> </div>	
STEP 3	<p>Clamp and Cut the Cord:</p> <ul style="list-style-type: none"> • Change gloves. If this is not possible, wash gloved hands. • Clamp (or tie) the cord, using sterile instruments and materials. • Lacerate two ties tightly around the cord at 2 cm and 5 cm from the baby's abdomen. • Cut between ties with a sterile scissors or a new sterile razor blade. • If blood oozes, place another tie between the skin and first tie. • DO NOT apply any substance to stump. • DO NOT bind or bandage stump. • Leave stump uncovered. 	
STEP 4	<p>Place the baby on mother's chest in skin-to-skin contact and have the mother start breastfeeding:</p> <ul style="list-style-type: none"> • Put the baby on the mother's chest between her breasts for skin to skin warmth. • Place an identifying label on baby. • Cover the baby's head with a hat. • Cover both the mother and baby with a warm cloth or blanket. • Have the mother start breastfeeding. 	
STEP 5	<p>Give Eye Care: Shortly after breastfeeding and within 1 hour after birth, give the newborn eye care.</p> <ul style="list-style-type: none"> • Wash your hands. • Wipe each eye with a separate piece of dry clean cloth or two different clean corners of the same cloth used to dry the baby. • Apply an anti-microbial eye medicine to both eyes within one hour of birth. • Use one of the recommended drugs to prevent infection, such as 1% silver nitrate eye drops, 2.5% povidone-iodine eye drops, or 1% tetracycline ointment. • DO NOT wash away the anti-microbial medicine. 	

↓

STEP 6	<p>Examine and Immunize the baby:</p> <ul style="list-style-type: none"> • Attend to the baby and perform complete examination including weighing the baby. • After examination, interact with the mother and inform her about the baby's condition. If all the findings are normal, tell her that the baby is healthy and normal. • Administer VitaminK1 injection 1mg intra muscularly. • Vaccinate the baby against Tuberculosis, Poliomyelitis soon after birth, unless directed otherwise. <p>BCG: Give a single dose of 0.05 ml intra dermal on the left deltoid region.</p> <p>Oral Polio Vaccine (OPV): Put two drops of vaccine on the baby's tongue</p>	  
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STEP 7	<p>Counsel the mother:</p> <ul style="list-style-type: none"> • Discuss routine care of the baby and danger signs that would require immediate medical attention • Emphasize the importance of exclusive breastfeeding • Describe the optimal positions and attachment for successful breastfeeding. • Discuss how to manage common breastfeeding problems • Schedule a follow up visit for mother and newborn. 	
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Note:

Situation I: When the baby starts breathing normally or cries while drying –

After eye care the wet cloth can be discarded and baby may be covered with a warm, dry towel and after this Cord Care can be done.

Situation II: When the baby does not breathe or cry while drying - quickly clamp and cut the cord, Discard wet cloth and cover baby covered with a dry warm cloth.

Resuscitation should be initiated

CHECKLIST 35.1: BATHING AN INFANT

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR BATHING AN INFANT	
STEP	SCORE
GETTING READY	
1. Gather equipment, keep room temperature warm and free of drafts, and keep water warm (100°).	
2. Perform hand hygiene.	
PROCEDURE	
3. Wash infant's face with water (may hold infant in football hold or lay infant down; always keep one hand on infant at all times).	
4. Using football hold, wash hair.	
5. Dry face and hair with towel.	
6. If baby has crusted material around eyes, clean with cotton swab soaked in water, inside to outer edge of eye. .	
7. If nostrils require further cleaning, use clean water-soaked Q-tips.	
8. Remove clothes/diaper, keeping areas not being washed unexposed to prevent heat loss.	
9. Wash and rinse infant's body, paying special attention to genitalia and buttocks.	
10. Dry well (especially between skin folds).	
11. Replace diaper and dress in clean T-shirt.	
12. Return equipment to proper storage area.	
13. Perform hand hygiene.	
14. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ QUALIFIED ☐ NOT QUALIFIED TO BATHE AN INFANT

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

CHECKLIST 35.2: NEWBORN EYE CARE

(To be completed by Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

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Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR NEWBORN EYE CARE	
STEP/TASK	SCORE
GETTING READY	
1. Prepare necessary equipment.	
2. Tell the mother what is going to be done and encourage her to ask questions.	
3. Wash hands thoroughly with soap and water and dry.	
4. Place the baby on her/his back and clean eyes.	
APPLICATION OF OINTMENT <u>OR</u> INSTILLATION OF SOLUTION	
A. Tetracycline Ointment	
A5. Open the eye gently.	
A6. Apply a small amount of ointment to the inside of the lower lid of each eye.	
A7. Recap tube and perform hand hygiene.	
B. 1% Silver Nitrate Solution <u>OR</u> 2.5% Povidone-Iodine Solution	
B5. Open eye gently.	
B6. Apply 1 drop of solution onto each eye.	
B7. Recap container and perform hand hygiene.	
RECORD	
8. Record procedure on birth record.	
9. Perform hand hygiene.	
10. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PROVIDE NEWBORN EYE CARE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

CHECKLIST 35.3: NEWBORN EXAMINATION

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR NEWBORN EXAMINATION	
STEP	SCORE
GETTING READY	
1. Greet the woman respectfully.	
2. Prepare the necessary equipment.	
3. Check the medical record of mother and newborn: complications during labor, delivery, or postpartum; special treatments; Vitamin K injection; immunization with OPV, BCG, and hepatitis B vaccines.	
4. Tell the woman and her family what is going to be done and encourage her to ask questions.	
5. Listen to what the woman has to say.	
PROCEDURE	
6. Ask the newborn's name, gender, and date and time of birth.	
7. Ask the mother and family if the newborn has any problems.	
8. Ask the mother about breastfeeding.	
9. Ask whether the baby is urinating.	
10. Ask whether the baby has passed stool: ask about color and consistency.	
11. If there are no medical records available, ask the mother and family whether the baby has had OPV, BCG and HBV immunizations.	
12. Perform hand hygiene	
13. Remove the newborn's clothing and place the baby on a clean, warm surface where the mother and family can see, or examine the baby in the mother's arms.	
14. Check the newborn's general appearance and alertness, breathing, heart rate, temperature (see checklist below), skin, and muscle tone. Check the baby's feet for warmth.	
15. Observe breastfeeding: check positioning, attachment, and suckling.	
16. Put on gloves.	
17. Examine the head, face, mouth, and eyes. Check the mouth for thrush and the eyes for abnormal discharge.	
18. Examine the chest for symmetrical movement with breathing and crying.	
19. Examine the cord stump for bleeding, discharge, and redness.	
20. Examine the genitalia.	
21. Examine the spine.	

CHECKLIST FOR NEWBORN EXAMINATION	
STEP	SCORE
22. Examine the upper and lower limbs, checking the skin, soft tissues, bones, and symmetrical movement. Check the skin for pustules, rash, and jaundice.	
23. Inform the mother of findings and ask her if she has additional questions.	
24. Perform hand hygiene.	
25. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM NEWBORN EXAMINATION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 35.3.1: MEASURING INFANT BODY TEMPERATURE

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

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Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR MEASURING INFANT BODY TEMPERATURE	
STEP	SCORE
GETTING READY	
1. Gather necessary supplies.	
2. Tell the mother what is going to be done and encourage her to ask questions.	
3. Perform hand hygiene.	
AXILLARY TEMPERATURE	
4. Place the baby on her/his back or side on a clean, warm surface.	
5. Shake the thermometer until it is below 35°C.	
6. Place the tip of the thermometer high in the apex of the axilla and hold the arm continuously against the body for at least 3 minutes.	
7. Remove the thermometer and read the temperature.	
RECTAL TEMPERATURE	
8. Place the baby on her/his back on a clean, warm surface.	
9. Shake the thermometer until it is below 25°C.	
10. Lubricate the tip of the thermometer with a water-based lubricant.	
11. Gently grasp the baby's ankles and hold the legs in the knee-chest position.	
12. Place the thermometer in the rectum to a maximum depth of 2 cm and hold it there for at least 3 minutes.	
13. Remove the thermometer and read the temperature.	
POST-PROCEDURE TASKS	
14. Wipe the thermometer with a disinfectant solution after each use.	
15. Perform hand hygiene.	
16. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO MEASURE INFANT BODY TEMPERATURE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 35.4: NEWBORN RESUSCITATION

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR NEWBORN RESUSCITATION	
STEP	SCORE
GETTING READY	
1. Gather necessary equipment and supplies and perform hand hygiene.	
2. Ensure the equipment is functioning properly.	
3. Place the newborn on her/his back on a clean, warm surface.	
4. Keep the newborn wrapped or covered, except for the face and upper chest.	
5. Tell the mother what is happening and have an assistant provide reassurance.	
PROCEDURE	
6. Position the head in a slightly extended position to open the airway.	
7. Clear the airway, if necessary, by suctioning the mouth first and then the nose .	
8. Place the mask on the baby's face so that it covers the chin, mouth, and nose.	
9. Squeeze the bag with 2 fingers only or with the whole hand, depending on the size of the bag.	
10. Check the seal by ventilating two or three times and observing the rise of the chest.	
11. If the newborn's chest is rising, ventilate at a rate of 40 breaths per minute.	
12. If the newborn's chest is not rising, determine why, correct the problem, and continue to ventilate.	
13. Ventilate for 1 minute, using oxygen, if available, and then stop and quickly assess the baby for spontaneous breathing and color. If breathing is normal, stop ventilating: <ul style="list-style-type: none"> If the newborn is gasping, not breathing, or the respiratory rate is less than 30 breaths per minute, continue ventilating. 	
14. If the newborn starts crying, stop ventilating and observe the baby's respiratory rate for 5 minutes after crying stops. If breathing is normal, stop ventilating: <ul style="list-style-type: none"> If the newborn is gasping, not breathing, or the respiratory rate is less than 30 breaths per minute, continue ventilating. 	
15. If the newborn is not breathing regularly after 20 minutes of ventilation, continue ventilation with oxygen and organize transfer and refer the infant to a tertiary hospital or specialized care center, if possible. (Have CM start IV or gastric tube if available.)	
16. If there is no gasping or breathing at all after 20 minutes of ventilation, stop ventilating, provide emotional support to mother and family, and allow the mother and/or family members to hold the newborn, if they wish.	
17. Keep the newborn under a radiant warmer until the newborn's condition is stable.	

CHECKLIST FOR NEWBORN RESUSCITATION	
STEP	SCORE
18. Monitor the newborn's respiratory rate and observe for other signs of illness.	
19. Provide reassurance to the mother.	
POST-RESUSCITATION STEPS	
20. Soak suction catheters in 0.5% chlorine solution for 10 minutes for decontamination.	
21. Wipe exposed surfaces of the bag and mask with a gauze pad soaked in 60–90% alcohol or 0.5% chlorine solution and rinse immediately.	
22. Perform hand hygiene.	
23. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM NEWBORN RESUSCITATION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 36: PREPARATION AND ADMINISTRATION OF ORAL REHYDRATION SALTS (ORS)

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR PREPARATION AND ADMINISTRATION OF ORAL REHYDRATION SALTS (ORS)	
STEP	SCORE
GETTING READY	
1. Perform hand hygiene and wash mixing spoon.	
PROCEDURE	
2. Empty ORS packet and stir it with a clean spoon.	
3. After every watery stool, give ORS in the following amounts: <ul style="list-style-type: none"> • If <2 years old, ¼ to ½ glass or cup • If 2–10 years old, ½ to 1 glass or cup • If over 10 years old, 1–2 glasses or cups 	
4. Take the child to clinic if not better in 5 days or if the child shows signs of severe dehydration.	
5. Continue to give the child as much ORS, breast milk, and food as she wants.	
6. If the child vomits, usually the ORS has been given too quickly or the fluid is too cold:	
7. Wait 5–10 minutes and give the ORS more slowly. If the child continues to vomit, and is unable to keep ORS down, the child should be taken to the clinic.	
8. Perform hand hygiene with water and soap after changing diapers and washing the child/helping child to use the toilet.	
ADMINISTERING ORS/WATER-SUGAR-SALT (WSS) TO THE CHILD WITH DIARRHEA AND NO DEHYDRATION	
9. After every watery stool, give ORS in the following amounts by cup, glass, or spoon (never use a feeding bottle): <ul style="list-style-type: none"> • If <2 years old, ¼ to ½ glass or cup • If 2–10 years old, ½ to 1 glass or cup • If over 10 years old, 1–2 glasses or cups 	
10. Take the child to clinic if not better in 14 days or if shows signs of severe dehydration.	
11. Continue to give the child as much ORS breast milk and food as she wants.	
12. If the child vomits, usually the ORS has been given too quickly or the fluid is too cold:	
13. Wait 5–10 minutes and give the ORS more slowly.	

CHECKLIST FOR PREPARATION AND ADMINISTRATION OF ORAL REHYDRATION SALTS (ORS)	
STEP	SCORE
14. Perform hand hygiene.	
15. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PREPARE AND ADMINISTER ORAL REHYDRATION SALTS (ORS)

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

36.1: SUPPLEMENT: THE “SIMPLE SOLUTION”— HOMEMADE ORAL REHYDRATION SALTS (ORS) RECIPE

Preparing 1 (one) Litre Solution Using Salt, Sugar, and Water at Home

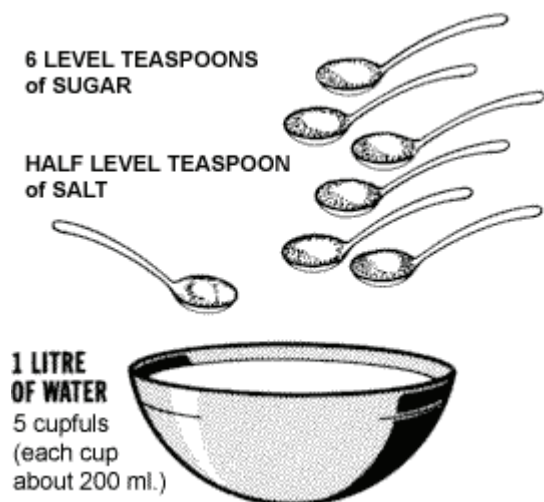
Mix an oral rehydration solution using the following recipe:

Ingredients:

- Six (6) level teaspoons of sugar
- Half (1/2) level teaspoon of salt
- One liter of clean drinking or boiled water and then cooled—**5 cupfuls (each cup about 200 mL)**

Preparation Method:

- Stir the mixture until the salt and sugar dissolve.



Effective Homemade Remedy for Watery Diarrhea

An efficient and effective homemade remedy to be used when watery diarrhea strikes and is a good substitute for oral rehydration salts:

Ingredients:

- 1/2 to 1 cup precooked baby rice cereal or 1½ tablespoons of granulated sugar
- 2 cups of water
- 1/2 teaspoon salt

Instructions:

Mix well the rice cereal (or sugar), water, and salt together until the mixture thickens but is not too thick to drink.

Give the mixture often by spoon and offer the child as much as he or she will accept (every minute if the child will take it).

Continue giving the mixture with the goal of replacing the fluid lost: one cup lost, give a cup. Even if the child is vomiting, the mixture can be offered in small amounts (1–2 teaspoons) every few minutes or so.

- Banana or other non-sweetened mashed fruit can help provide potassium.
- Continue feeding children when they are sick and continue breastfeeding if the child is being breastfed.

QUESTIONS ON SOLUTIONS MADE AT HOME

Q. How do I measure the salt and sugar?

Different countries and different communities use various methods for measuring the salt and sugar.

- Finger pinch and hand measuring, and the use of local teaspoons, can be taught successfully.
- A plastic measuring spoon is available from Teaching Aids at Low Cost (TALC) with proportions to make up 200 mL of sugar/salt solution.

Whatever method is used, people need to be carefully instructed in how to mix and use the solutions.

Do not use too much salt. If the solution has too much salt, the child may refuse to drink it. Also, too much salt can, in extreme cases, cause convulsions. Too little salt does no harm but is less effective in preventing dehydration.

A rough guide to the amount of salt is that the solution should **taste no saltier than tears**.

Q. How much solution do I feed?

Feed after every loose stool.

Adults and large children should drink at least 3 quarts or liters of ORS a day until they are well.

Each Feeding:

- **For a child under the age of two**
Between a quarter and a half of a large cup
- **For older children**
Between a half and a whole large cup
- **For Severe Dehydration:**
Drink sips of the ORS (or give the ORS solution to the conscious dehydrated person) every 5 minutes until urination becomes normal. (It's normal to urinate four or five times a day.)

Q. How do I feed the solution?

- Give it slowly, preferably with a teaspoon.
- If the child vomits it, give it again.

The drink should be given from a cup (feeding bottles are difficult to clean properly). Remember to feed sips of the liquid slowly.

Q. What if the child vomits?

If the child vomits, wait for 10 minutes and then begin again. Continue to try to feed the drink to the child slowly, small sips at a time.

The body will retain some of the fluids and salt needed even though there is vomiting.

Q. For how long do I feed the liquids?

Extra liquids should be given until the diarrhea has stopped. This will usually take between 3 and 5 days.

Q. How do I store the ORS solution?

Store the liquid in a cool place. Chilling the ORS may help. If the child still needs ORS after 24 hours, make a fresh solution.

10 THINGS YOU SHOULD KNOW ABOUT RE-HYDRATING A CHILD

1. Wash your hands with soap and water before preparing solution.
2. Prepare a solution, in a clean pot, by mixing:
 - Six (6) level teaspoons of sugar and half (1/2) level teaspoon of salt
 - or**
 - 1 Packet of oral rehydration salts (ORS) 20.5 grams
 - mix with**
 - One liter of clean drinking or boiled water (after cooled)
 - Stir the mixture until all the contents dissolve.
3. Wash your hands and the baby's hands with soap and water before feeding the solution.
4. Give the sick child as much of the solution as she/he needs, in small amounts frequently.
5. Give the child alternately other fluids, such as breast milk and juices.
6. Continue to give solids if the child is 4 months or older.
7. If the child still needs ORS after 24 hours, make a fresh solution.
8. ORS does not stop diarrhea. It prevents the body from drying up. The diarrhea will stop by itself.
9. If child vomits, wait 10 minutes and give it ORS again. Usually vomiting will stop.
10. If diarrhea increases and/or vomiting persists, take the child over to a health clinic.

Note:

People often refer to home-prepared oral rehydration solutions as "home-brew." This should be discouraged because the word brew implies either:

- **Fermenting**, which in fact is an obstacle to some home-prepared solutions, especially those made with rice-powder, or
- **Boiling** (as in tea) which, especially with sugar and salt or using packets of ORS, should not be done because it decomposes the sugar, or caramelizes.

CHECKLIST 37: OXYGEN ADMINISTRATION

(To be completed by the **Assessor**)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR OXYGEN ADMINISTRATION	
STEP	SCORE
GETTING READY	
1. Greet the patient and relatives respectfully.	
2. Verify order: Check the patient's chart for physician's order.	
3. Verify the patient's identity.	
4. Clearly explain to the patient or relatives the purpose of the oxygen, and answer any questions.	
5. Assemble all needed materials on a tray.	
6. Perform hand hygiene and put on gloves.	
PROCEDURE	
7. Attach oxygen delivery device.	
8. Position the client (lay the client in supine position and flex neck).	
9. Adjust elastic bandage on face mask or nasal cannula.	
10. Maintain sufficient slack on oxygen tubing and secure it to the patient.	
11. Assess flow meter and oxygen source for proper set-up and prescribed flow rate.	
12. Monitor the situation levels using pulse oximetry if required.	
13. Dispose of the equipment safely to prevent the transmission of infection.	
14. Properly remove and dispose of gloves.	
15. Make plan for continue care.	
16. Report all findings to In-Charge.	
17. Perform hand hygiene.	
18. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM OXYGEN ADMINISTRATION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 37.1: APPLYING A NASAL CANNULA

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

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Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR APPLYING A NASAL CANNULA	
STEP	SCORE
GETTING READY	
1. Review safety precautions necessary when oxygen is in use (place no smoking signs in appropriate areas).	
2. Perform hand hygiene.	
3. Explain procedure to the client.	
4. Connect the nasal cannula to the oxygen set-up with humidification, if one is in use. Adjust the flow rate as ordered by physician,	
5. Check that oxygen is flowing out of prongs.	
PROCEDURE	
6. Place the prongs in the client's nostrils and tubing over and behind each ear, adjusting so that it fits comfortably under chin or around the client's head.	
7. Use gauze pads at ear beneath the tubing as necessary.	
8. Encourage the client to breathe through his or her nose with mouth closed.	
9. Assess and chart the client's response to therapy.	
10. Remove and clean the cannula and assess nares at least every 8 hours or according to facility standards. Check nares for evidence of irritation or bleeding.	
11. Perform hand hygiene.	
12. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ QUALIFIED ☐ NOT QUALIFIED TO APPLY A NASAL CANNULA

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

CHECKLIST 38: PHYSICAL EXAMINATION

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

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Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR PHYSICAL EXAMINATION	
STEP	SCORE
GETTING READY	
1. Greet the patient and relatives by name and introduce yourself respectfully.	
2. Verify the patient's identity by checking name tag and compare with the patient's chart.	
3. Clearly explain to the patient or relatives the purpose of physical assessment, and answer honestly any question that the patient or relatives ask.	
4. Verify order: Check the patient's chart for physician's order.	
5. Assemble all needed materials on a tray and place it at the bedside.	
6. Ensure patient privacy.	
7. Explain procedure.	
PROCEDURE	
8. Position the patient for examination.	
9. Perform hand hygiene.	
10. Put on disposable gloves.	
11. Drape the patient.	
12. Carry out physical examination with a systematic approach (starting from head to toes).	
13. Palpation: Palpate organs.	
14. Percussion: Strike body part to determine location, size, and density of the body part by the tone.	
15. Auscultation: Listen to sound produced by the body, usually with the stethoscope.	
16. Discard of all used materials properly.	
17. Remove and dispose of gloves properly.	
18. Report all findings to In-Charge.	
19. Perform hand hygiene.	
20. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM A PHYSICAL EXAMINATION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST FOR BREAST EXAMINATION	
STEP	SCORE
16. Teach the woman how to perform a breast self-examination.	
Following the Examination	
17. Ask the woman to get dressed.	
18. Explain any abnormal findings and what needs to be done. If the examination is normal, tell the woman everything is normal and healthy and when she should return for a repeat examination. Ask if she has any questions.	
19. Refer as required.	
20. Perform hand hygiene.	
21. Document procedure and/or findings.	
TOTAL	

Pass Score 17/20

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** to PERFORM BREAST EXAMINATION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 38.1: ABDOMINAL EXAMINATION

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

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Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR ABDOMINAL EXAMINATION ²	
STEP	SCORE
GETTING READY	
1. Perform hand hygiene.	
2. Greet the patient respectfully.	
3. Explain procedure to the patient.	
4. Ask the patient to lie down and keep arms at sides or folded across the chest.	
PROCEDURE	
5. If the patient complains of pain, ask him/her to point to the place where it hurts.	
6. Visually inspect the abdomen for rashes, sores, scars, and contour.	
7. Observe movement of the abdominal wall associated with respiration, peristalsis, or aortic pulsations. Note any visible masses.	
8. Using a stethoscope, auscultate the abdomen in all four quadrants for bowel sounds and vascular sounds. Use the bell of the stethoscope to listen to the aorta.	
9. Percuss the abdomen lightly in all four quadrants to determine distribution of gas and fluid, position and size of the liver and spleen.	
10. Palpate the abdomen gently with a light dipping motion of the fingers in all four quadrants moving in a clockwise direction. When moving the hand from place to place, raise it off the skin.	
11. To feel abdominal masses, use the fingers for deep palpation. Note location, size, and tenderness of any masses. When deep palpation is difficult, use two hands, one on top of the other. Apply pressure with the top hand while concentrating on feeling with the lower hand.	
12. To assess for rebound tenderness: slowly and deeply dip fingers into the abdominal wall. Then release the pressure in a quick smooth motion. Ask the patient what hurt more: pressing in or letting go.	
13. Perform hand hygiene.	
14. Document procedure and/or findings.	
TOTAL	

² Adapted from: Zambia MOH Student Learning Guide 2007.

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM AN ABDOMINAL EXAMINATION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 38.2: BREAST EXAMINATION

(To be used by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

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Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

CHECKLIST FOR BREAST EXAMINATION	
STEP	SCORE
GETTING READY	
1. Greet the woman with respect and kindness.	
2. Explain the purpose and the procedure of the breast exam to the woman.	
3. Ask the woman for permission to examine her breasts.	
4. Ask the woman to undress from her waist up and sit on the examining table with her arms at her sides. Make a cover available for warmth and privacy.	
5. Wash your hands thoroughly and dry them while the woman is getting ready.	
6. Put on new examination or high-level disinfected surgical gloves on both hands.	
BREAST EXAMINATION	
With the Woman Sitting	
7. Look at the breasts and note any differences in: <ul style="list-style-type: none"> • Shape • Size • Dimpling 	
8. Look at the nipples and note: <ul style="list-style-type: none"> • Size • Shape • Direction in which they point • Rashes or sores • Discharge 	
9. Look at breasts while the woman has hands over her head and then while she presses her hands on her hips. Check to see if breasts hang evenly.	
With the Woman Lying Down on the Examining Table	
10. Note any differences between the right and left breasts.	
11. Ask her to raise her left arm and place her hand under her head.	
12. Palpate the entire breast using the spiral, wedged, or vertical strip technique. Note any lumps or tenderness.	
13. Palpate the tail of Spence and check for enlarged lymph nodes or tenderness on both left and right side.	
14. Squeeze the nipple gently and note any discharge.	
15. Repeat these steps for the right breast. If necessary, repeat this procedure with the woman sitting up and with her arms at her sides.	

CHECKLIST 38.3: CARDIAC EXAMINATION

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

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Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR CARDIAC EXAMINATION	
STEP	SCORE
GETTING READY	
1. Perform hand hygiene.	
2. Greet the patient respectfully and with kindness.	
3. Explain procedure to the patient.	
PROCEDURE	
4. Measure and record blood pressure.	
5. Measure and record heart rate by checking radial pulse. With pads of index and middle fingers, gently compress the radial artery until pulsation is detected.	
6. Observe the appearance of the neck arteries and veins.	
7. Place your left thumb (or index and middle fingers) on the right carotid artery in the lower third of neck and feel for pulsations. Repeat the procedure for the left carotid artery. <i>Never</i> press both carotids at the same time.	
8. Cup a hand under the patient's elbow and palpate the brachial artery using the index and middle fingers or thumb of your opposite hand. Feel for the pulse just medial to the biceps tendon. The patient's arm should rest with the elbow extended, palm up. Repeat procedure on the opposite side.	
9. Press nail beds for capillary refill and check for cyanosis.	
10. Feel the top of the foot (not the ankle) just lateral to the tendon of the great toe. Palpate the dorsalis pedis pulse. Repeat procedure on the opposite side.	
11. Curve your fingers behind and slightly below the medial malleolus of the ankle. Palpate the posterior tibial pulse. Repeat procedure on the opposite side.	
12. Inspect lower extremities for edema, pitting, ulcers, and swollen veins.	
13. Have the patient lie flat and inspect the anterior chest wall. Palpate the apical impulse at or medial to the midclavicular line in the 4 th or 5 th interspace.	

CHECKLIST FOR CARDIAC EXAMINATION	
STEP	SCORE
14. With the patient lying flat, listen to the heart with the diaphragm of the stethoscope pressed firmly against the chest: <ul style="list-style-type: none"> • Aorta: right 2nd interspace close to sternum • Pulmonic: left 2nd interspace close to sternum • Erb's: left 3rd interspace close to sternum • Tricuspid: left 4th and 5th interspace close to sternum • Mitral: left 5th interspace lateral at the apex 	
15. Use the bell at the apex and along the lower sternal border to hear murmurs. Apply the bell lightly.	
16. Other options: Ask the patient to roll partly onto the left side. Place the bell of the stethoscope lightly on the apical impulse.	
17. Other options: Ask the patient to sit up, lean forward, exhale completely, and then stop breathing. Listen along the left sternal border and at the apex with the diaphragm of the stethoscope. Pause periodically so the patient may breathe. Use the bell to listen to both carotids for bruits while holding breath on each side. Listen below xyphoid process for aortic aneurysms.	
18. Perform hand hygiene.	
19. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM A CARDIAC EXAMINATION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (*in case of need to remediate or other*):

38.4: HISTORY AND PHYSICAL

ID:
Name

Age

Gender

Hospital number

CC:

HPI: *Characterization of symptoms: when did you first feel unwell?*

course of sx
radiation

progression since onset
personal hx

constant vs. intermittent
function/quality of life

System-related ROS:

REVIEW HPI *"Is there anything else you would like to tell me?"*

IMPRESSION: 1.	PLAN: 1.
-------------------	-------------

PMH:
General:

SURGICAL & OB :

Type

Date

Complications

Result

Major Illnesses –
Stroke/TIA

DM
Lung

HTN
Liver

Lipids
Kidney

CAD
CHF

Thyroid
CA

MEDICAL HX: Hospitalizations and major medical problems:

Diagnosis

Date

Presentation

Treatment

Sequelae

Hospitalizations

MEDS:

Dose

Freq

Route

Since when

Side Effects

ALLERGIES:

Health maintenance: PAP
Immunizations

Infectious illnesses: measles, Pentavalent, polio, BCG, yellow fever, Hep B

Injuries/disability:Recent travel:

SOCIAL HX:

Occupation:Hometown:

Partner:

Children:

Smoking

EtOH

Drug Use

Diet?Exercise?Caffeinated beverages?

SEXUAL HX: Sexually active? Y NMen, women, or both?
Having any concerns? Frequency , type, satisfaction with intercourse
age at 1st intercourse_____ number of partners_____

G ___ P ____

FAMILY HX: *age, current health, major illnesses, cause of death*

Father

Mother

Grandparents

Siblings

CAD?CHF?HTN?STROKE/TIA?

CANCER?COPD?Asthma?GI?Kidney?Arthritis?

DM?Thyroid?CNS/PNS (seizure, paralysis)?Psychiatric?

ROS:

GENERAL –fevers, chills, sweats; weight +/-; D in appetite; fatigue

SKIN – rashes, lesions, sweating, pruritis, easy bruising, difficult healing swelling, petechiae, photosensitivity, changes in hair or nails

HEAD / NECK – headache, dizziness, trauma, swollen LNs

EYES – vision changes; glasses, blurring; diplopia; pain inflammation/discharge, dry eyes, scotoma, photophobia

EARS – hearing loss, pain, tinnitus, vertigo; drainage

NOSE – epistaxis, discharge, sneezing; obstruction, chronic sinusitis

MOUTH/THROAT – teeth, gums, oral ulcers, pain dry mouth, trouble swallowing, hoarseness, sore throat

CV – chest pain or pressure, palpitations, edema, syncope exercise tolerance, fatigue, circulatory probs; murmurs, claudication

LUNGS – dyspnea on exertion; cough, sputum, hemoptysis asthma or wheezing; cyanosis, orthopnea, PND

BREASTS – pain, masses, discharge, change in appearance, self-exam

GI – nausea / vomiting, dysphagia, odynophagia; dyspepsia reflux or heartburn, loss of appetite, food intolerance

abdominal pain; hematemesis; jaundice, change in bowel habits diarrhea / constipation; melena, hematochezia

GU – obstructive symptoms, dysuria, frequency, urgency hematuria, pyuria, previous UTI's; discharge, nocturia, incontinence

MENSTRUAL – menarche; last period, length of cycle, duration of flow how regular, how heavy; pain w/ menstruation or intercourse vaginal bleeding or discharge, intermenstrual bleeding; age of menopause

ENDOCRINE – thyroid, adrenal, hormonal; temperature intolerance; osteoporosis; edema, polyuria, polydipsia, polyphagia

MS – arthralgias, arthritis, ROM, stiffness, myalgias swelling, erythema, tenderness; gout, neck or low back pain

NEURO – syncope, vertigo, LOC, seizures numbness / tingling, weakness, equilibrium, coordination/gait

PSYCH – anxiety; mania; memory loss, depression: interest, guilt, energy, sleep, concentration, appetite, psychomotor, suicide

www.med4uola.com/thanku/keep

PHYSICAL EXAM: **wash hands**

VITAL SIGNS: T _____ P _____ RR _____ BP _____

ht. _____ wt. _____ BMI _____ Pain _____ Pulse ox _____ %

GENERAL: _____

SKIN: _____ cap refill _____

clubbing _____ cyanosis _____ edema _____

HEAD: NC/AT _____

face _____ CN V _____ VII _____

EYES: conjunctiva _____ EOMI _____

VFI _____ PERRLA _____

ophthalmoscopic _____

EARS: TMs _____ hearing _____

NOSE: _____

THROAT: _____ palatal elev _____ gag reflex _____

NECK: _____ LNs _____

Carotid pulses _____ bruits _____

Thyroid _____

LUNGS: _____ inspect _____

auscultate _____

percuss (w/ diaph excursion) _____

CV: palpate PMI _____

auscultate @ 4 areas w/diaphragm: rate & rhythm, murmurs, rubs, gallops, click _____

Pt. LYING DOWN:

CV: Auscultation apex _____

ABDOMEN: _____

_____ bowel sounds _____ bruits _____

percuss _____ liver span _____

palpate _____

PULSES: dorsalis pedis _____ posterior tibial _____ edema _____

femoral pulse (+ auscultate) _____

LE MS exam: _____

Pt. SITTING: CVA tenderness _____

UE MS exam: wrists _____ elbows _____

shoulders _____ neck _____

NEURO: Mental status _____ CNs _____

Sensation: touch _____ pain _____ position _____ vibration _____

Reflexes: biceps _____ brachioradialis _____ triceps _____

patellar _____ achilles _____ babinski _____

Cerebellar: finger tapping _____ heel to shin _____

Pt. STANDING

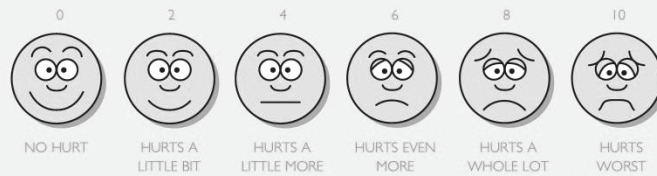
Spine: _____

UE drift _____ Romberg _____

Gait and station _____ swing and stance _____ heel / toe walking _____



Wong-Baker FACES Pain Rating Scale



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Instructions for FACES Pain Rating Scale

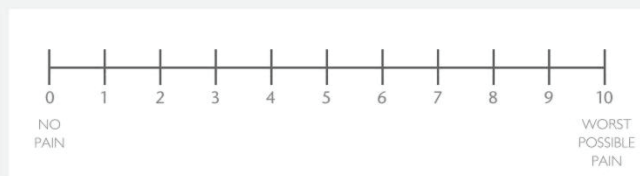
This rating scale is recommended for children ages 3 and older.

Brief word instruction: Point to each face using the words to describe the pain intensity. Ask the child to choose the face that best describes his or her own pain, and report the appropriate numbers to your nurse.

Explain to the child that each face is for a child who has no pain (hurt) or some, or a lot. Face 0 doesn't hurt at all. Face 2 hurts just a little bit. Face 4 hurts a little more. Face 6 hurts even more. Face 8 hurts a whole lot. Face 10 hurts as much as you can imagine, although you don't have to be crying to have this worst pain. Ask the child to choose the face that best describes how much pain he or she has.

Verbal Pain Assessment Scale

Ask your child to rate pain on a scale of 0 to 10. This rating scale is recommended for children over 8 years.



38.5: HEARING CHECK

There is no need for a checklist since it is part of a regular physical exam and you will not be assessed on this, but here is a guide below.

1. Place both hands at the side of the patient's ears.
2. Rub the thumb and the first two fingers together and ask, "Can you hear me evenly on both sides?"
3. If the person says anything other than yes, take the next step.
4. Have the person plug one ear with one finger and whisper three two-syllable words in the other ear as you stand behind them diagonally at the opposite ear. If they are able to get two of the three words in both ears, check them again in another year. *Ensure that you pick three different words for the opposite ear.* If they are not able to and a specialist is available, refer them. If no specialist is available, work with the family to make sure they are sensitive to the situation and alter their speech in an appropriate and respectful manner. For example, the person losing hearing should not be yelled at from a distance. Family and friends should make an effort to come nearer and speak clearly in order to communicate well.

Adapted from: Chase Brexton Health Services, Baltimore, Maryland, USA.

CHECKLIST 38.6: ILIOPSOAS SIGN

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR ILIOPSOAS SIGN	
STEP	SCORE
GETTING READY	
1. Perform hand hygiene.	
2. Greet the patient respectfully.	
3. Explain procedure to the patient.	
PROCEDURE	
4. Ask the patient to lie flat with legs straight.	
5. Place your hand just above the patient's right knee.	
6. Ask the patient to raise the right thigh and leg against your hand. Note: Increased abdominal pain with this maneuver is a positive result.	
7. Repeat with other leg.	
8. Document findings. If positive result, start transfer process to hospital.	
9. Perform hand hygiene.	
10. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ QUALIFIED ☐ NOT QUALIFIED TO PERFORM THE ILIOPSOAS SIGN

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

CHECKLIST 38.7: MEASURING BLOOD PRESSURE

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR MEASURING BLOOD PRESSURE	
STEP	SCORE
GETTING READY	
1. Ensure that the client is in a sitting position for 5 minutes, with the upper arm at level of the heart, legs uncrossed, feet flat on the floor, client relaxed.	
2. Perform hand hygiene.	
3. Determine if pulses are equal.	
PROCEDURE	
Checking Blood Pressure	
4. Apply cuff:	
• Use correct cuff size.	
• Palpate brachial artery.	
• Center cuff bladder over brachial artery.	
• Place cuff 1 inch above antecubital space.	
• Wrap cuff snugly.	
5. Determine systolic pressure by palpation and determine the maximum inflation level (MIL).	
6. Wait 1–2 minutes (between any inflations of the cuff) and determine pulse rate and respirations (meanwhile taking both for 30 seconds and multiplying by 2). If high, check both arms.	
7. Determine blood pressure by the auscultatory method:	
• Place stethoscope ear tips properly into ears.	
• Palpate brachial artery.	
• Place stethoscope diaphragm over brachial artery.	
• Close the valve, but not tightly.	
• Pump up cuff rapidly to 20–30 mm Hg to MIL.	
• Deflate cuff at the rate of 2 mm Hg per second.	
• Record BP, pulse, and respirations on flow sheet.	
8. Perform hand hygiene.	
9. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO MEASURE BLOOD PRESSURE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 38.9: MUSCULOSKELETAL EXAMINATION³

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR MUSCULOSKELETAL EXAMINATION	
STEP	SCORE
GETTING READY	
1. Perform hand hygiene.	
2. Greet the patient respectfully and with kindness.	
3. Explain procedure to the patient.	
PROCEDURE	
4. Observe and then palpate hands, arms, and shoulders.	
5. Inspect the hands for any deformities. Check the color of the nails.	
6. Inspect the legs and feet for any swelling, skin integrity, color, symmetry, and hair distribution.	
7. Palpate feet and lower legs for edema.	
8. Observe the client’s ease of movement, muscle strength, and coordination as client moves from supine to sitting position.	
9. Test range of motion and muscle strength in the hips, knees, ankles, feet and spine.	
10. Perform hand hygiene.	
11. Document procedure and/or findings.	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM A MUSCULOSKELETAL EXAMINATION

Assessor’s Signature _____ Date _____

Assessor’s Printed Name _____

Comments (in case of need to remediate or other):

³ Adapted from: Zambia MOH Student Learning Guide 2007.

CHECKLIST 38.10: NEURO CHECK

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR NEURO CHECK	
STEP	SCORE
GETTING READY	
1. Perform hand hygiene.	
2. Greet the patient respectfully.	
PROCEDURE	
3. Ask the patient the following questions: <ul style="list-style-type: none"> • What is your full name? • Who is the current president? • What is the year? • Where are you right now? • What did you eat for breakfast today? • How old are you? • When were you born? • Can you count backwards from 20 to 1? • What is your mother's name? 	
4. Inspect the size, shape, and symmetry of the pupils.	
5. Darken the room and test pupillary reaction to light. Ask the patient to look into the distance and shine a bright light from the side into each pupil, one at a time.	
6. Perform hand hygiene.	
7. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM NEURO CHECK

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (*in case of need to remediate or other*):

38.10.1: COMA SCALES (PEDIATRIC AND ADULT)

Blantyl Coma Scale (Pediatric)

Section	Features	Score
1. Eye Movements	Directed (follows mother's face)	1
	Not directed	0
	Sub-Total Score Section 1	1
2. Verbal Response	Appropriate cry	2
	Moan or inappropriate cry	1
	None	0
	Sub-Total Score Section 2	3
3. Best Motor Response	Localizes painful stimulus ^a	2
	Withdraws limb from pain ^b	1
	Nonspecific or absent response	0
	Sub-Total Score Section 3	3
Total score (Section 1 +2+3)		7

a) Press your knuckles firmly on the patient's sternum.

b) Press firmly on patient's thumbnail bed with the side of a horizontal pencil.

Glasgow Coma Scale (Adult)

Section	Features	Score
1. Eyes Opening	Spontaneously	4
	To speech	3
	To pain	2
	None	1
	Sub-Total Score Section 1	
2. Best Verbal Response	Oriented	5
	Confused	4
	Inappropriate words	3
	Incomprehensible sounds	2
	None	1
	Sub-Total Score Section 2	
3. Best Motor Response	Obeys commands	6
	Localizes pain	5
	Withdraw from pain	4
	Flexion to pain	3
	Extension on pain	2
	None	1
Total score (Section 1 +2+3)		

A score of 3 indicates deep coma while a score of 15 indicates fully conscious.

38.10.2: LOBES OF THE BRAIN AND CRANIAL NERVES JOB AID

Health Assessment- Neuro Reference

CEREBRUM	FUNCTION	QUESTION OR ASSESSMENT
Frontal Lobe	Personality, judgment, abstract reasoning, social behavior, motor control of voluntary movement, organization, concentration	Mental status check Muscle resistance test
Parietal Lobe	Sensory areas for touch, pain and temperature, understanding of speech and language, thought expression	Mental status check Sharp versus dull
Temporal Lobe	Hearing, memory of hearing and vision	Whisper test
Occipital Lobe	Visual recognition Focus of the eye	Object identification Accommodation
Cerebellum	Function	Question or Assessment
Cerebellum	Balance, posture, coordination, muscle tone	Gait test Stand on one leg test Muscle resistance test
Brainstem	Function	Question or Assessment
	Breathing	Respiratory rate and rhythm
	Cranial Nerves	See table below on Cranial Nerves

Cranial Nerve/Main Function/Test	Cranial Nerve/Main Function/Test
I - Smell	VII - facial symmetry, close eye lids
II - Pupils	VIII - hearing
III/IV/VI - EOM, III - to nose and up to the sky; IV - to floor, VI - looking to the side	IX and X - cough and gag
V - facial sensation (sharp/dull)	XI - shoulder shrug
	XII - tongue position and symmetry

CHECKLIST 38.11: ORAL EXAMINATION/EXAMINATION OF THE PHARYNX

(To be completed by the **Assessor**)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR ORAL EXAMINATION/EXAMINATION OF THE PHARYNX	
STEP	SCORE
GETTING READY	
1. Perform hand hygiene.	
2. Greet the patient respectfully.	
3. Explain procedure to the patient.	
4. Sit the patient upright in a chair or on an examination table.	
5. Sit in front of the patient with a flashlight or penlight.	
6. Put on clean examination gloves.	
PROCEDURE	
7. Inspect the lips for color, texture and symmetry. Note any lumps, ulcers, cracking, or scales.	
8. Ask the patient to open his/her mouth.	
9. Inspect the oral mucosa and gums for color of mucous membranes and lesions.	
10. Inspect the teeth for dental caries and architecture of the hard palate.	
11. Ask the patient to put out his or her tongue. Inspect for symmetry, white patches, reddened areas, nodules, and ulcers.	
12. Ask the patient to say "ah" or yawn. Depress the tongue with a tongue depressor and inspect the pharynx and tonsils for color, discharge, size, and lesions.	
13. Discard the tongue depressor in the appropriate waste receptacle.	
14. Remove gloves and discard in appropriate waste receptacle.	
15. Perform hand hygiene.	
16. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM AN ORAL EXAMINATION/
EXAMINATION OF THE PHARYNX

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (*in case of need to remediate or other*):

CHECKLIST 38.12: RECTAL EXAMINATION

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR RECTAL EXAMINATION	
STEP	SCORE
GETTING READY	
1. Perform hand hygiene.	
2. Greet the patient respectfully and with kindness.	
3. Explain procedure to the patient.	
4. Position the patient on his/her side or in the lithotomy position.	
5. Put on clean examination gloves and adjust lighting as needed.	
PROCEDURE	
6. Spread the buttocks apart to expose the anus. Check for fissures, lesions, scars, inflammation, discharge, and hemorrhoids.	
7. Apply water- soluble lubricant to the gloved index finger.	
8. Ask the patient to strain down and place the pad of the index finger over the anus.	
9. When the sphincter relaxes, gently insert the index fingertip into the anal canal, in a direction pointing toward the umbilicus.	
10. If the sphincter tightens, pause and reassure the patient. When the sphincter relaxes, try again.	
11. Insert the index finger into the rectum as far as possible. Rotate your hand clockwise and then counterclockwise. Note any nodules, irregularities, induration, or tenderness.	
12. Remove the index finger and inspect the glove for stool, blood, and mucus.	
13. Test the fecal matter for occult blood* if test kits are available.	
14. Discard gloves and used test kits in appropriate waste receptacle.	
15. Perform hand hygiene.	
16. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM A RECTAL EXAMINATION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

*To test for occult blood, apply the fecal matter to the test paper, turn over, and drop the testing solution to the other side. If the paper turns blue, it indicates that blood is present.

CHECKLIST 38.13: RESPIRATORY EXAMINATION

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR RESPIRATORY EXAMINATION ¹	
STEP	SCORE
GETTING READY	
1. Perform hand hygiene.	
2. Greet the patient respectfully.	
3. Explain procedure to the patient.	
PROCEDURE	
4. Inspect the trachea and note any deviation from its usual midline position.	
5. Observe the patient’s respirations: rate, depth, rhythm, and effort of breathing. Look for accessory muscle use.	
6. From a midline position behind the patient, note the shape of the chest and the way in which it moves. Ask the patient to take a deep breath in and out and inspect for symmetry of chest movement.	
7. Palpate the chest for lumps, areas of tenderness, and any abnormalities of the overlying skin.	
8. At the back, percuss all lung fields for resonance, moving symmetrically side to side for comparison.	
9. Using a stethoscope, auscultate the chest at the back for breath sounds and added sounds such as wheezes. Listen to lung fields moving from side to side for comparison. Ask the patient to breathe deeply through the mouth.	
10. Perform hand hygiene.	
11. Document procedure and/or findings.	
TOTAL	

¹ Adapted from: Zambia MOH Student Learning Guide 2007.

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM A RESPIRATORY EXAMINATION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 38.14: TAKING AXILLARY TEMPERATURE WITH MERCURY THERMOMETER

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST: TAKING AXILLARY TEMPERATURE WITH MERCURY THERMOMETER	
STEP	SCORE
GETTING READY	
1. Gather thermometer and alcohol swabs.	
2. Perform hand hygiene.	
3. Tell the patient that you are going to take her/his temperature and need to go under or inside her/his shirt to get to the armpit.	
PROCEDURE	
4. Shake the thermometer vigorously.	
5. Place the thermometer in axilla and position arm across chest to keep the thermometer in place.	
6. Leave in place for 6 minutes.	
7. Perform hand hygiene.	
8. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO TAKE AN AXILLARY TEMPERATURE WITH MERCURY THERMOMETER

Assessor's Signature _____

Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

CHECKLIST 38.15: TAKING AN APICAL PULSE

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR TAKING AN APICAL PULSE	
STEP	SCORE
GETTING READY	
1. Perform hand hygiene.	
2. Identify the patient and explain procedure to the patient.	
PROCEDURE	
Taking the apical pulse	
3. Locate apical pulse (at approximately 5th intercostal space at mid-clavicular line).	
4. Place diaphragm of stethoscope over appropriate area and count rate for 1 full minute.	
5. Accurately report rate, rhythm of pulse and record on flow sheet. Report also if PMI is shifted to the right beyond mid-clavicular line. This may indicate an enlarged heart and will need follow-up.	
6. Perform hand hygiene.	
7. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO TAKE AN APICAL PULSE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

CHECKLIST 38.16: TAKING A RADIAL PULSE

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR TAKING A RADIAL PULSE	
STEP	SCORE
GETTING READY	
1. Perform hand hygiene.	
2. Identify the patient and explain procedure to the patient.	
PROCEDURE	
3. Accurately locate and palpate radial pulse using the pads of middle 2 or 3 fingers.	
4. Count rate for 30 seconds and multiply by two, or 15 seconds and multiply by four.	
5. Accurately report rate, rhythm, and quality of pulse and record rate on paper or electronic flow sheet.	
6. Perform hand hygiene.	
7. Document procedure and/or findings.	

Learner IS ☐ QUALIFIED ☐ NOT QUALIFIED TO TAKE A RADIAL PULSE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

CHECKLIST 38.17: TAKING RESPIRATIONS

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR TAKING RESPIRATIONS	
STEP	SCORE
PROCEDURE	
1. After measuring pulse, keep fingers on pulse and observe respiratory rate for 30 seconds and multiply by two. (May move patient's hand to rest on her/his chest.)	
2. Accurately report rate, rhythm, and quality of respirations and record on flow sheet.	
3. Perform hand hygiene.	
4. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ QUALIFIED ☐ NOT QUALIFIED TO TAKE RESPIRATIONS

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

38.18: THYROID ASSESSMENT SUPPLEMENT

Iodine is needed for the production of thyroid hormone and is the most common cause of thyroid enlargement (goiter). The body does not make iodine, so it is an essential part of the diet. If there is not enough iodine, the thyroid gland will get larger to try and make more hormones for the body. People can prevent this enlargement by getting iodine in their food. Common sources of iodine in food are iodized table salt, saltwater fish, cheese, cows' milk, eggs, meat, and yogurt. Lack of iodine can lead to mental retardation in infants and children whose mothers were iodine deficient during pregnancy.

Patients with a large goiter may experience symptoms of choking, especially when lying down, and difficulty swallowing and breathing.

Severe iodine deficiency in the pregnant mother has been associated with miscarriages, stillbirth, preterm delivery, and congenital abnormalities in their babies. Children of mothers with severe iodine deficiency during pregnancy or while breastfeeding can have mental retardation and problems with growth, hearing, and speech. This is the most common preventable cause of mental retardation in the world. Even mild iodine deficiency during pregnancy may be associated with low intelligence in children.

Adapted from: American Thyroid Association.

http://www.thyroid.org/patients/patient_brochures/iodine_deficiency.html

CHECKLIST 38.18.1: SWALLOW TEST

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR SWALLOW TEST	
STEP	SCORE
GETTING READY	
1. Perform hand hygiene.	
2. Greet the patient respectfully.	
3. Explain procedure to the patient.	
PROCEDURE	
4. Inspect the trachea and note any deviation from its usual midline position.	
5. Ask the patient to tip the head back slightly and swallow a sip of water or tea. Watch for upward movement of the thyroid gland, noting its contour and symmetry. The thyroid cartilage, the cricoid cartilage, and the thyroid gland all rise with swallowing and then fall to their resting positions.	
6. Stand in front of the patient and push the trachea to the right with your left thumb with 3 fingers on the right side of the trachea. Ask the patient to swallow and feel the thyroid lobe on the right.	
7. Then push the trachea to the left with your right thumb with 3 fingers on the left side of the trachea. Repeat swallow to feel thyroid lobe on the left.	
8. Optional: Palpate the thyroid from behind. Place fingers of both hands on the patient's neck so that the index fingers are just below the cricoids. Ask the patient to sip and swallow water as before. Feel for any glandular tissue rising under the finger pads. Move fingers laterally as needed.	
9. Note the size, shape, and consistency of the gland and identify any nodules or tenderness.	
10. Perform hand hygiene.	
11. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM THE SWALLOW TEST

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

38.19 VITAL SIGNS INTRODUCTION

Goal: By the end of lab, the Learner will be able to demonstrate, and correctly measure, a radial and apical pulse, blood pressure, and respirations, and take an oral temperature using mercury thermometers. The learner will also be able to measure standing height and weight.

Key areas of concentration:

1. Become familiar with equipment used in measuring vital signs, e.g., aneroid sphygmomanometer; stethoscope; thermometers; and how to use the equipment.
2. Correctly and accurately take a radial pulse, count respirations, and take a blood pressure. Learners most frequently have a problem with pressing too hard or too lightly when taking a pulse. When measuring blood pressure, learners have great difficulty with the fine motor skill of gently releasing the pressure, and difficulty in hearing all of the sounds.
3. Correctly identify the appropriate route for taking a temperature, i.e., oral, rectal, or axillary, based on scenario of age or condition of patient.
4. Be able to identify when an apical pulse is needed, e.g., irregular pulse.
5. Be able to trouble-shoot problems with vital sign measurement, e.g., problems with blood pressure (wrong cuff size, faint sounds, very low readings).
6. Recognize rate, rhythm, ease, and depth of respiratory patterns, e.g., Cheyne-Stokes, tachypnea, etc.
7. Be able to obtain a height and weight on the standing scale (in kilograms and pounds).
8. Documents vital signs accurately.

Equipment Needed per Station

Stethoscopes:

- Single: 1 per learner
- Double-headed: 1 per group

Aneroid sphygmomanometer per group

2 Oral thermometers

Alcohol with swabs or alcohol wipes

Equipment shared between groups:

Scales

At the **vital signs** station, the learner will be able to take a BP accurately (within 2–4 mmHg, systolic and diastolic), count a pulse accurately (within 2–4 beats), and count respirations accurately (within 2 breaths). The learner should follow proper procedure while doing vital signs.

VITAL SIGNS SUPPLEMENT

HIGH FEVER (Hyperpyrexia)

- A. Fevers over 104 F. (40° C.) axillary or 105 F. orally are dangerous and may cause death. Remove blankets and clothing and SPONGE such a patient immediately (with ice added to the water if necessary). Fanning the wet patient may also help. Give IBUPROFEN or PARACETAMOL to lower the temperature.
- B. Search for the cause of the fever.
- C. Malaria can be treated in the clinic. Most other causes of hyperpyrexia must be sent to the hospital. Any patient who seems severely ill should be sent immediately to the hospital.

CHECKLIST 39: POSTNATAL DISCHARGE INSTRUCTIONS— NEWBORN DANGER SIGNS

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

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Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR POSTNATAL DISCHARGE INSTRUCTIONS – NEWBORN DANGER SIGNS	
STEP	SCORE
GETTING READY	
1. Greet the woman respectfully.	
2. Ensure the woman’s comfort.	
PROCEDURE	
3. Maintain/ensure confidentiality.	
4. Encourage questions.	
5. Listen attentively to the woman.	
6. Use visual aids and anatomic models appropriately.	
7. Assess the woman’s baseline understanding of infant care.	
8. Describe deviations from normal newborn feeding.	
9. Describe management of newborn colic.	
10. Describe signs and symptoms of newborn jaundice.	
11. Describe signs and symptoms of newborn infection.	
12. Ensure the mother’s understanding of how to access the health care system if a complication is suspected.	
13. Record counseling.	
14. Perform hand hygiene.	
15. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO CONDUCT POSTNATAL DISCHARGE
INSTRUCTIONS – NEWBORN DANGER SIGNS

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 39.1: PRE-DISCHARGE POSTPARTUM INTERVIEW AND PHYSICAL EXAMINATION (EXAM MAY BE WITHIN 6 WEEKS)

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

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Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed versus sterilized

Learner _____

Date _____

CHECKLIST FOR PRE-DISCHARGE POSTPARTUM INTERVIEW AND PHYSICAL EXAMINATION (EXAM MAY BE WITHIN 6 WEEKS)	
STEP	SCORE
GETTING READY	
1. Prepare the necessary equipment.	
2. Greet the woman respectfully and with kindness and introduce yourself.	
3. Offer the woman a seat.	
4. Tell the woman what you are going to do and encourage her to ask questions.	
5. Listen to what the woman has to say.	
HISTORY (ASK/CHECK RECORD)	
6. When and where did you deliver?	
7. How are you feeling?	
8. Have you had any pain, fever, or heavy bleeding since delivery?	
9. Do you have any problem passing urine?	
10. Have you decided on a contraceptive/family planning method? Are you using LAM?	
11. Do you have any concerns?	
12. Check record for any other complications during delivery or postpartum or special treatments.	
PHYSICAL EXAMINATION (LOOK/FEEL)	
13. Wash hands thoroughly with soap and water and dry with a clean dry cloth or air dry.	
14. Help the woman onto the examination table and make sure that she is draped or covered appropriately throughout the examination.	
15. Measure the woman's blood pressure, temperature, and pulse.	
16. Check that uterus is well-contracted (hard and round).	
17. Look at pad for amount of bleeding/lochia and note smell.	
18. Look at vulva and perineum for cleanliness, swelling, and pus.	
19. Check palms and conjunctiva for pallor.	
20. Check for other problems.	
21. Wash hand thoroughly with soap and water and dry with a clean dry cloth or air dry.	

CHECKLIST FOR PRE-DISCHARGE POSTPARTUM INTERVIEW AND PHYSICAL EXAMINATION (EXAM MAY BE WITHIN 6 WEEKS)	
STEP	SCORE
POSTPARTUM CARE	
22. Check record for syphilis screening status and arrange for screening if not done during pregnancy.	
23. Check the woman's tetanus toxoid (TT) status and respond according to need.	
24. Check the woman's supply of iron/folate and respond according to need.	
25. Check if vitamin A given and respond according to need.	
26. Ensure that the patient has received family planning counseling if desired, and information about LAM. Supply family planning supplies if appropriate.	
27. Provide counseling and advice about danger signs and the need to seek immediate medical help, day or night, if they occur.	
28. Discuss how to prepare for an emergency.	
29. Advise the woman to go to clinic or health center as soon as possible if she develops any problems that are not an emergency.	
30. Provide advice and counseling about self-care and postpartum clinic visits.	
31. Make arrangements for as need for follow-up care.	
ASSESS BREASTFEEDING (ASK/LOOK)	
32. How is breastfeeding going?	
33. Are you having any difficulty?	
34. How do your breasts feel?	
35. How many times in 24 hours has your baby been breastfeeding?	
36. Does your baby seem satisfied with the feeds?	
37. Have you fed your baby any other foods or fluids?	
38. How long do you plan to breastfeed?	
39. Has the baby breastfed in the previous hour? If no, ask the mother to put the baby to breast.	
40. Observe attachment.	
41. Observe suckling.	
42. Observe positioning.	
43. Provide advice and counseling about breastfeeding, if any problems observed during assessment or reported by mother.	
44. Answer any additional questions the woman has.	
45. Perform hand hygiene.	
46. Document procedure and/or findings.	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO CONDUCT PRE-DISCHARGE POSTPARTUM INTERVIEW AND PHYSICAL EXAMINATION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

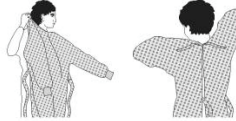
40: PPE JOB AID

SEQUENCE FOR DONNING PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required; e.g., Standard and Contact, Droplet or Airborne Infection Isolation.

1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



2. MASK OR RESPIRATOR

- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator



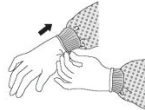
3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit



4. GLOVES

- Extend to cover wrist of isolation gown



SECUENCIA PARA PONERSE EL EQUIPO DE PROTECCIÓN PERSONAL (PPE)

El tipo de PPE que se debe utilizar depende del nivel de precaución que sea necesario; por ejemplo, equipo Estándar y de Contacto o de Aislamiento de infecciones transportadas por gotas o por aire.

1. BATA

- Cubra con la bata todo el torso desde el cuello hasta las rodillas, los brazos hasta la muñeca y dóblela alrededor de la espalda
- Átesela por detrás a la altura del cuello y la cintura

2. MÁSCARA O RESPIRADOR

- Asegúrese los cordones o la banda elástica en la mitad de la cabeza y en el cuello
- Ajuste la banda flexible en el puente de la nariz
- Acomódese en la cara y por debajo del mentón
- Verifique el ajuste del respirador

3. GAFAS PROTECTORAS O CARETAS

- Colóquelas sobre la cara y los ojos y ajústela

4. GUANTES

- Extienda los guantes para que cubran la parte del puño en la bata de aislamiento

USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

UTILICE PRÁCTICAS DE TRABAJO SEGURAS PARA PROTEGERSE USTED MISMO Y LIMITAR LA PROPAGACIÓN DE LA CONTAMINACIÓN

- Mantenga las manos alejadas de la cara
- Limite el contacto con superficies
- Cambie los guantes si se rompen o están demasiado contaminados
- Realice la higiene de las manos

SEQUENCE FOR REMOVING PERSONAL PROTECTIVE EQUIPMENT (PPE)

Except for respirator, remove PPE at doorway or in anteroom. Remove respirator after leaving patient room and closing door.

1. GLOVES

- Outside of gloves is contaminated!
- Grasp outside of glove with opposite gloved hand; peel off
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist
- Peel glove off over first glove
- Discard gloves in waste container



2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield is contaminated!
- To remove, handle by head band or ear pieces
- Place in designated receptacle for reprocessing or in waste container



3. GOWN

- Gown front and sleeves are contaminated!
- Unfasten ties
- Pull away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard



4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- Grasp bottom, then top ties or elastics and remove
- Discard in waste container



SECUENCIA PARA QUITARSE EL EQUIPO DE PROTECCIÓN PERSONAL (PPE)

Con la excepción del respirador, quítese el PPE en la entrada de la puerta o en la antesala. Quítese el respirador después de salir de la habitación del paciente y de cerrar la puerta.

1. GUANTES

- ¡El exterior de los guantes está contaminado!
- Agarre la parte exterior del guante con la mano opuesta en la que todavía tiene puesto el guante y quíteselo
- Sostenga el guante que se quitó con la mano enguantada
- Deslice los dedos de la mano sin guante por debajo del otro guante que no se ha quitado todavía a la altura de la muñeca
- Quítese el guante de manera que acabe cubriendo el primer guante
- Arroje los guantes en el recipiente de desechos

2. GAFAS PROTECTORAS O CARETA

- ¡El exterior de las gafas protectoras o de la careta está contaminado!
- Para quitárselas, tómelas por la parte de la banda de la cabeza o de las piezas de las orejas
- Colóquelos en el recipiente designado para reprocessar materiales o de materiales de desecho

3. BATA

- ¡La parte delantera de la bata y las mangas están contaminadas!
- Desate los cordones
- Tocando solamente el interior de la bata, pásela por encima del cuello y de los hombros
- Voltee la bata al revés
- Dóblela o enróllela y deséchela

4. MÁSCARA O RESPIRADOR

- La parte delantera de la máscara o respirador está contaminada — ¡NO LA TOQUE!
- Primero agarre la parte de abajo, luego los cordones o banda elástica de arriba y por último quítese la máscara o respirador
- Arrójela en el recipiente de desechos

PERFORM HAND HYGIENE IMMEDIATELY AFTER REMOVING ALL PPE

EFFECTÚE LA HIGIENE DE LAS MANOS INMEDIATAMENTE DESPUÉS DE QUITARSE CUALQUIER EQUIPO DE PROTECCIÓN PERSONAL



CHECKLIST 40.1: PUTTING ON AND REMOVING STERILE GLOVES

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR PUTTING ON AND REMOVING STERILE GLOVES	
STEP	SCORE
GETTING READY	
1. If surgical gloves are being put on for patient care, introduce yourself respectfully, verify the patient's identity and check for latex allergy (may require substitute for latex surgical gloves).	
2. Check that the sterile surgical glove package is dry, unopened, and not out of date.	
3. Remove any jewelry, make sure that your nails are short and that you have no artificial nails or nail polish.	
4. Perform hand hygiene (handwashing or surgical hand scrubbing). See. Infection Prevention: Using Hand Hygiene Module for details.	
PROCEDURE	
5. Place the unopened glove package on a clean, dry surface above waist height.	
6. Peel back the top layer of the outside package and remove the inner package.	
7. Place the inner package on the work surface with the "cuff end" next to your body.	
8. Fold open the top flap, then the bottom and sides. (Do not touch the inner surface of the package or gloves.)	
9. With the thumb and forefinger of your non-dominant hand, grasp the folded glove cuff for the dominant hand and lift it from the inner package. (Do not touch any unsterile item.)	
10. While holding the glove with its fingers hanging down, insert the fingers of your dominant hand (palm up) into the glove and pull the glove on using your non-dominant hand. (Leave the cuff folded until the opposite hand is gloved.)	
11. Place the fingers of your gloved hand inside the cuff of the remaining glove and lift it from the inner wrapper, being careful not to touch anything.	
12. Insert the fingers of your non-dominant hand into the glove and pull it on, being careful the hand does not touch the outer surface of the glove.	
13. Slide your fingers under the cuff of the other glove and fully extend the cuff up the forearm, touching only the outside (sterile side) of the glove.	
14. Repeat this step with the other glove.	
15. Hold your hands and arms above your waist to prevent contaminating the gloves.	
16. Use your dominant hand to grasp the opposite glove near the cuff end on the outside exposed area.	

CHECKLIST FOR PUTTING ON AND REMOVING STERILE GLOVES	
STEP	SCORE
17. Pull the glove off by inverting it as it comes off while keeping the contaminated area on the inside.	
18. Place the inverted gloves immediately in the nearest color-coded (Biohazard) bag or container.	
19. Wash and dry your hands, or apply an alcohol-based handrub.	
20. Grasp the contaminated glove by the cuff with the thumb and forefinger and pull it off by inverting it.	
21. Drop the contaminated glove in the nearest color-coded (Biohazard) bag or container.	
22. Ask the circulating (OR) assistant to open a sterile surgical glove package and place the glove package on a clean, dry surface.	
23. Insert the fingers of the ungloved hand into the glove and pull it on, being careful the hand does not touch the outer surface of the glove.	
24. Fully extend the cuff up the forearm, touching only the outside of the sterile glove.	
25. Perform hand hygiene.	
26. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PUT ON AND REMOVE STERILE GLOVES

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (*in case of need to remediate or other*):

CHECKLIST 40.2: SETTING UP A STERILE FIELD

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

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Learner _____

Date _____

CHECKLIST FOR SETTING UP A STERILE FIELD	
STEP	SCORE
GETTING READY	
1. Make sure the sterile drape package and other sterile items to be added to the sterile field are available (e.g., sterile wrapped gauze, medicine bowls, suture and forceps, or other surgical instruments). Use disposable supplies if possible.	
2. Check that the sterile drape package is dry, unopened, not torn or damaged, and the expiration date has not passed.	
3. Place the sterile package on a waist-high table or other workplace.	
4. Introduce yourself respectfully, verify the patient or client's identity, and provide for privacy if appropriate (i.e., close the door or bedside curtains).	
5. Check for latex allergy. If yes, make sure non-latex gloves are available if needed and the sterile pack does not contain items made of latex.	
6. Explain what you are going to do and answer any questions.	
7. Perform hand hygiene.	
PROCEDURE	
8. Open the outer cover of the sterile drape package and remove the sterile drape by lifting it carefully by its corners.	
9. Hold the drape at waist height away from your body and allow it to unfold without touching anything.	
10. Place the unfolded drape on the work surface with the moisture-resistant side, which usually is blue or shiny, down. Do not allow the drape to touch anything.	
Adding Wrapped Sterile Items (suture, gauze packs or instruments)	
11. Hold the sterile wrapped item to be placed on the sterile field in your dominant hand with the top flap opening facing away from you.	
12. Use the other hand to grasp the top flap by reaching around it, unfold the top flap and then the two side flaps, exposing the sterile item.	
13. Perform hand hygiene.	
14. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO SET UP A STERILE FIELD

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 41: SPUTUM SPECIMEN COLLECTION

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

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Learner _____

Date _____

CHECKLIST FOR SPUTUM SPECIMEN COLLECTION	
STEP	SCORE
GETTING READY	
1. Greet the patient and relatives by name and introduce yourself respectfully.	
2. Verify the patient's identity by checking name tag and compare with the patient's chart.	
3. Clearly explain to the patient or relatives the purpose of the specimen collection and the procedure, and answer honestly any question that the patient or relatives ask.	
4. Verify order: Check the patient's chart for physician's order.	
5. Assemble all needed materials on a tray.	
6. Perform hand hygiene.	
7. Put on gloves.	
8. Get the client's permission to ensure proper positioning.	
PROCEDURE	
9. Advise the client not to touch the inside of the container.	
10. Assist the client to collect specimen in the open air, in the area designated, avoid direct contact with other client and staff, and expectorate the specimen directly into the container.	
11. Keep the outside of the container free from sputum if possible.	
12. Teach the client how to hold a pillow firmly against an abdominal incision.	
13. Assist the client to a sitting or standing position.	
14. Ask the client to hold the sputum container on the outside, OR	
15. Put on gloves and hold the specimen container.	
16. Perform hand hygiene.	
17. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM SPUTUM SPECIMEN COLLECTION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

42: STOOL AND URINE COLLECTION CONSIDERATIONS

COLLECTING A STOOL SPECIMEN

Purpose: for laboratory analysis, usually ordered x3

Equipment:

Specimen or bedpan

Stool specimen cup

Tongue blade

Procedure

Position specimen in toilet to collect stool or place patient on bedpan.

Take tongue blade to lift out some stool and place in specimen container.

Label, send to lab, and chart.

Hemacult test (blood in stool) can be done on the nursing unit:

See supplies in nursing lab.

If stool is for ova and parasite, it must be sent to lab while the specimen is warm, ½ to 1 hour after collection.

URINE SPECIMENS

Routine Urine Analysis (Rt. U/A)

Purpose: to know general characteristics of urine and what this information can tell about the patient's general condition.

Collection: void into clean cup or take from catheter; need about 20 cc.

Clean Caught (Midstream)

Purpose: usually for culture and sensitivity (bacteria, WBC, RBC) when patient can void without contaminating specimen.

Procedure: (Collection)

- Clean meatus with antiseptic wipes.
Women: Wipe front to back each side, keep labia apart.
Men: Wipe down each side of penile tip at meatus.
- Have patient start to pass urine, then collect in sterile specimen cup. Need at least 10 cc for culture.
Do not put fingers inside of cup.
Do not put inside of cap down on any surface.

CHECKLIST 42.1: STOOL SPECIMEN COLLECTION

(To be completed by the Assessor)

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Learner _____

Date _____

CHECKLIST FOR STOOL SPECIMEN COLLECTION	
STEP	SCORE
GETTING READY	
1. Greet the patient and relatives by name and introduce yourself respectfully.	
2. Verify the patient's identity by checking name tag and compare with the patient's chart.	
3. Clearly explain to the patient or relatives the purpose of the specimen collection and the procedure, and answer honestly any question that the patient or relatives ask.	
4. Verify order: Check patient's chart for physician's order.	
5. Assemble all needed materials on a tray.	
6. Perform hand hygiene.	
7. Put on gloves and label the specimen container with the patient's name and hospital number.	
8. Get the client's permission to ensure proper positioning.	
PROCEDURE	
9. If the patient is able, have her/him hold the specimen cup under the rectum above the toilet. If not, have the patient defecate in the bedpan and use a wooden spatula to obtain a sample and place it in the sterile container.	
10. Deliver the specimen to the lab.	
11. Perform hand hygiene.	
12. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM STOOL SPECIMEN COLLECTION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 42.2: URINE SPECIMEN COLLECTION

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR URINE SPECIMEN COLLECTION	
STEP	SCORE
GETTING READY	
1. Greet the patient and relatives by name and introduce yourself respectfully.	
2. Verify the patient's identity by checking name tag and compare with the patient's chart.	
3. Clearly explain to the patient or relatives the purpose of the specimen collection and the procedure, and answer honestly any question that the patient or relatives ask.	
4. Verify order: Check the patient's chart for physician's order.	
5. Assemble all needed materials on a tray.	
6. Perform hand hygiene.	
7. Put on gloves and label specimen container with the patient's name and hospital number.	
8. Get the client's permission to ensure proper positioning.	
PROCEDURE	
9. If the patient is able, have him/her hold the specimen cup under the urethra above the toilet. If not, have the patient urinate in the bedpan and pour a sample into the sterile container.	
10. Deliver the specimen to the lab.	
11. Perform hand hygiene.	
12. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM URINE SPECIMEN COLLECTION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

43: STANDARD PRECAUTION GUIDELINES

Handwashing (or using an antiseptic handrub) <ul style="list-style-type: none">• After touching blood, body fluids, secretions, excretions and contaminated items• Immediately after removing gloves• Between patient contact
Gloves <ul style="list-style-type: none">• For contact with blood, body fluids, secretions and contaminated items• For contact with mucous membranes and non-intact skin
Masks, goggles, face masks <ul style="list-style-type: none">• Protect mucous membranes of eyes, nose and mouth when contact with blood and body fluids is likely
Gowns <ul style="list-style-type: none">• Protect skin from blood or body fluid contact• Prevent soiling of clothing during procedures that may involve contact with blood or body fluids
Linen <ul style="list-style-type: none">• Handle soiled linen to prevent touching skin or mucous membranes• Do not pre-rinse soiled linens in patient care areas
Patient care equipment <ul style="list-style-type: none">• Handle soiled equipment in a manner to prevent contact with skin or mucous membranes and to prevent contamination of clothing or the environment• Clean reusable equipment prior to reuse
Environmental cleaning <ul style="list-style-type: none">• Routinely care, clean and disinfect equipment and furnishings in patient care areas
Sharps <ul style="list-style-type: none">• Avoid recapping used needles• Avoid removing used needles from disposable syringes• Avoid bending, breaking or manipulating used needles by hand• Place used sharps in puncture-resistant containers
Patient resuscitation <ul style="list-style-type: none">• Use mouthpieces, resuscitation bags or other ventilation devices to avoid mouth-to-mouth resuscitation
Patient placement <ul style="list-style-type: none">• Place patients who contaminate the environment or cannot maintain appropriate hygiene in private rooms

CHECKLIST 44: SUTURE REMOVAL

(To be completed by the **Assessor**)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR SUTURE REMOVAL	
STEP	SCORE
GETTING READY	
1. Greet the patient and relatives by name and introduce yourself respectfully.	
2. Verify the patient's identity by checking name tag and compare with the patient's chart.	
3. Clearly explain to the patient or relatives clearly the purpose of suturing, and answer honestly any question that the patient or relatives ask.	
4. Verify order: Check the patient's chart for physician's order.	
5. Assemble all needed materials on a tray and place it at the bedside.	
6. Ensure the patient's privacy.	
7. Explain procedure.	
8. Assist the patient into a comfortable position.	
PROCEDURE	
9. Perform hand hygiene.	
10. Put on gloves.	
11. Remove dressing and clean the incision.	
12. Remove the sutures.	
13. Grasp the suture at the knot with a pair of forceps.	
14. Place the curved tip of the scissor under the suture as close as possible to the skin.	
15. With the forceps, pull the suture out in one piece. Inspect the suture to make sure that all is removed.	
16. Discard the suture onto a piece of sterile gauze or into the leak-proof bag.	
17. Clean and cover the incision.	
18. Instruct the client about follow-up wound care.	
19. Properly discard all used materials.	
20. Properly remove and dispose of gloves.	
21. Report all findings to the In-Charge.	

CHECKLIST FOR SUTURE REMOVAL	
STEP	SCORE
22. Perform hand hygiene.	
23. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM SUTURE REMOVAL

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 45.1: CONDUCTING A VACCINE SHAKE TEST

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR CONDUCTING A VACCINE SHAKE TEST	
STEP	SCORE
GETTING READY	
1. Perform hand hygiene with clean water and soap or use handrub.	
2. Take a vial of DPT, DPT-HepB, or TT vaccine of the same type and batch number as the vaccine you want to test and made by the same manufacturer.	
3. Clearly mark the vial as “frozen.”	
PROCEDURE	
4. Freeze the vial at -20°C overnight until the contents are completely solid.	
5. Let it thaw. Do not heat it.	
6. Take the “test” vial from the batch that you suspect has been frozen.	
7. Hold the “frozen” vial and the “test” vial together in one hand.	
8. Shake both vials vigorously for 10–15 seconds.	
9. Place both vials on a flat surface side by side and start continuous observation of the vials until the test is finished.	
10. Use an adequate source of light to compare the sedimentation between the vials.	
11. If the “test” vial creates sediments more slowly than the “frozen” vial, use the vaccine batch.	
12. If the sedimentation is similar in both vials OR if the “test” vial sedimentation is faster than the frozen vial, the vaccine is damaged. Discard all affected vaccine.	
13. Notify supervisor. Fill in loss/adjustment form.	
14. Perform hand hygiene.	
15. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO CONDUCT A VACCINE SHAKE TEST

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 45.2: LOADING A COLD BOX FOR USE IN OUTREACH PROCEDURE

(To be completed by the **Assessor**)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR LOADING A COLD BOX FOR USE IN OUTREACH PROCEDURE	
STEP	SCORE
GETTING READY	
1. Perform hand hygiene.	
2. Ensure that the cold box is intact with no cracks in the walls or lids. Small cracks can be repaired with duct tape.	
3. Ensure general cleanliness of interior and exterior of cold box. Clean with soap and water if necessary.	
PROCEDURE	
4. Check thermometers in the freezer and the main section of the refrigerator to ensure they are set at proper temperature(s) and the refrigerator is properly cooled.	
5. Quickly take all the frozen ice packs you need from the freezer and close the door.	
6. Put ice packs against each of the four sides of the cold box or vaccine carrier.	
7. Quickly remove all the vaccines and diluents needed from the main section of the refrigerator and close the door. (For outreach sessions, take unopened vials only.)	
8. Put the vaccines and diluents in the middle of the cold box or vaccine carrier. Vials may be kept in their boxes or packed without them depending on how many vials are needed.	
9. Ensure that DPT and TT vaccine vials do not touch the ice packs. Put newspaper or cardboard around them to protect them from freezing.	
10. Put a thermometer on top of the vaccines unless vaccine vial monitors are attached.	
11. Put ice packs on top of the vaccines.	
12. For vaccine carriers, place a foam pad on top of the ice packs.	
13. Close the carrier lid tightly.	

CHECKLIST FOR LOADING A COLD BOX FOR USE IN OUTREACH PROCEDURE	
STEP	SCORE
14. Maintain temperature in cold box/vaccine carrier below 8°C: <ul style="list-style-type: none"> • Keep lid tightly on the carrier in transit. • During sessions, keep opened vials on the foam pad of the vaccine carrier. The foam pad keeps vaccines inside the carrier cool while providing a place to hold and protect vaccine vials in use. • Do not put vials back inside the carrier after each use; lifting up the foam pad will make the inside of the carrier warm. • Keep cold boxes and vaccine carriers in the shade. Do not leave carriers in a vehicle that is standing in the sun. Take them out of the vehicle and put them in the shade. 	
15. Ensure that vaccine can still be used by shaking an ice pack from the cold box or carrier to be sure that it is still solid. If water splashing is heard, the ice pack has melted and the vaccines are too warm and must be discarded.	
16. Perform hand hygiene.	
17. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO LOAD A COLD BOX FOR USE IN OUTREACH PROCEDURE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 45.3: LOADING A VACCINE REFRIGERATOR

(To be completed by the Assessor)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR LOADING A VACCINE REFRIGERATOR	
STEP	SCORE
GETTING READY	
1. Perform hand hygiene.	
2. Prepare the necessary equipment and supplies.	
3. Ensure general cleanliness of interior and exterior of refrigerator. Clean with soap and water if necessary.	
PROCEDURE	
4. Check thermometers in the freezer and the main section of the refrigerator to ensure they are set at proper temperature(s) and the refrigerator is properly cooled.	
5. Freeze and store frozen ice packs in the freezer section of the refrigerator.	
6. Put vaccines and diluents on the top and middle shelves of the main section as follows: <ul style="list-style-type: none"> – OPV and measles vaccine on the top shelf – BCG, DPT, and TT vaccines on the middle shelves – Diluent next to the vaccines with which they were supplied 	
7. Check expiry dates for each vaccine while storing, and discard all vaccines and diluents beyond the expiry dates.	
8. Arrange the boxes of vaccine in stacks between which the air can move.	
9. Keep opened multi-use vials that have been taken out of the refrigerator in a special box in the main section labeled “returned.” Use these vials first in the next session.	
10. Do not put vaccines on the refrigerator door shelves.	
11. Do not keep any food, drink, or drugs in a vaccine refrigerator.	
12. Make a stock record. Fill in when you are storing or taking out vaccines.	
13. Perform hand hygiene.	
14. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO LOAD A VACCINE REFRIGERATOR

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 45.4: RECONSTITUTING MEASLES VACCINE

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR RECONSTITUTING MEASLES VACCINE	
STEP	SCORE
GETTING READY	
1. Prepare the necessary equipment and supplies.	
2. Do not begin the process until clients have arrived and you are ready to immunize.	
3. Do not use previously reconstituted vials of measles vaccine.	
PROCEDURE	
4. Read the label on the vaccine vial to be ensure: 1. The expiry date has not passed. 2. Seal intact and not used. 3. There are no cracks in the vial.	
5. Be sure the vaccine powder is at the bottom of the vial. If the powder is at the top of the vial, slowly shake it down to the bottom.	
6. Ensure that the vaccine and diluents have been stored under appropriate cold chain conditions.	
7. Read the label on the diluents ampoule to ensure: • It is the diluents sent by the manufacturer to be used specifically with the measles vaccine and specific vaccine vial size. • The expiry date has not passed. • There are no cracks in the ampoule.	
8. Perform hand hygiene.	
9. Put on clean examination gloves.	
10. Remove diluents cover or top.	
11. Remove the cover of the vaccine vial without touching the rubber septum.	
12. Holding the diluents ampoule horizontally, use a previously unused, sterile needle and syringe to draw up all of the diluents in the ampoule.	
13. Insert the needle of the syringe containing the diluents into the vaccine vial.	
14. Touch the tip of the needle to the side of the vaccine vial and slowly push the piston of the syringe. Empty the diluents into the vial to mix with the vaccine powder.	
15. Withdraw the solution of diluents and powder and empty into the vial two or three times until solution is adequately mixed OR remove the needle and syringe and gently roll the vial between your fingers to mix the contents until all of the vaccine powder has dissolved.	
16. Discard syringe and needle in a sharps container.	

CHECKLIST FOR RECONSTITUTING MEASLES VACCINE	
STEP	SCORE
17. Discard exam gloves in appropriate waste container.	
18. Document the date and time the vial was mixed.	
19. Perform hand hygiene.	
20. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO RECONSTITUTE MEASLES VACCINE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 45.5: VACCINATION EDUCATION AND ADMINISTRATION

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR VACCINATION EDUCATION AND ADMINISTRATION	
STEP	SCORE
GETTING READY	
1. Greet the patient respectfully.	
2. Ensure that you receive eligible people (children and women) from the health care provider, health educator, or other department for EPI.	
3. Screen eligible child or woman for immunization.	
PROCEDURE	
4. Ask the mother if the child or she has immunization card:	
• If yes, congratulate the parent or guardian.	
• If no, supply the card and educate on the importance of the card.	
5. Explain to the mother/father/caretaker which vaccination the child will receive.	
6. Ask the mother/father/caretaker to tell about the importance to immunization.	
7. Ask the mother/father/caretaker about when to come in for the next immunization.	
8. Inform the mother/father/caretaker about possibility of side effects and how to manage potential side effects of vaccines.	
9. Ask the mother/father/caretaker if they know the date of next immunization.	
VACCINATION ADMINISTRATION	
10. Perform hand hygiene.	
11. Explain to the mother/father/caretaker how to position the child for immunization.	
12. Talk to the baby or child in a soothing voice and be nice to the child and the mother throughout the visit.	
A13. Check for:	
• Correct vaccine	
• Date of expiry at least once, using the vial or container	
• Correct dose	
• Correct syringes (disposable, single-use syringe and needle)	
• Correct injection site:	

CHECKLIST FOR VACCINATION EDUCATION AND ADMINISTRATION	
STEP	SCORE
• BCG intra dermal at 0-degree angle in left upper arm	
• Measles: subcutaneous 45-degree angle in right middle arm	
• DPT+HB intramuscular in 90-degree angle in outer and middle side or right or left thigh	
• TT Intramuscular in 90-degree angle in upper left arm for CBA	
• OPV in 45-degree angle	
A14. Depending on vaccine, reconstitute per directions.	
A15. Draw up correct solution from correct vial (double check).	
A16. Remove visible dirt with cotton swab.	
A17. Administer vaccine at correct site by pressing the plunger.	
A18. If IM, pull back a little to ensure in the muscle and not a vessel (withdraw if not in the muscle).	
A19. Withdraw the needle and press with cotton wool over the injection site until bleeding stops.	
A20. Inject the vaccine.	
A21. Put the needle and syringe together in safety box (never recap or remove the needle).	
A22. Perform hand hygiene.	
A23. Record the information on the appropriate forms and the vaccination card.	
IMMUNIZATION OF ORAL VACCINE	
B13. Perform hand hygiene.	
B14. Check for:	
• Correct vaccine	
• Correct dose	
B15. Give the baby/child the oral vaccine and assure that the child has swallowed all of it.	
B16. Record the information on the appropriate forms and the vaccination card.	
B17. Perform hand hygiene.	
B18. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM VACCINE EDUCATION AND ADMINISTRATION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments (in case of need to remediate or other):

CHECKLIST 46: VENIPUNCTURE BLOOD COLLECTION

(To be completed by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR VENIPUNCTURE BLOOD COLLECTION	
STEP	SCORE
GETTING READY	
1. Greet the patient, if conscious, by name and introduce yourself.	
2. Verify the patient's identity by checking name tag and compare with the patient's chart.	
3. Clearly explain to the patient or relatives the purpose for the vein puncture, and answer honestly any questions that the patient or relatives ask.	
4. Prepare tray and assemble all materials.	
5. Wash your hands.	
6. Put on gloves properly.	
7. Prepare tray and assemble all materials.	
PROCEDURE	
8. Flush infusion tubing to remove air and place it on IV pole.	
9. Select and prepare the vein puncture site, select appropriate vein.	
10. Dilate the vein; apply tourniquet at the appropriate site, massage and swab the vein.	
11. Uncap and insert the appropriate size of cannula or butterfly.	
12. Observe for back flow of blood, then remove the needle, release tourniquet, and properly insert the cannula or butterfly, and flush with saline.	
13. Secure cannula or butterfly with adhesive tape.	
14. Attach infusion tubing or spigot.	
15. Ensure the appropriate infusion flow rate.	
16. Ensure proper disposal of waste; place needle in sharps container and other waste in medical waste container.	
17. Properly remove and dispose of gloves.	
18. Perform hand hygiene.	
19. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM VENIPUNCTURE – BLOOD
COLLECTION

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 47.1: CLEANING AND DRESSING A WOUND WITH A DRY, STERILE DRESSING

(To be completed by the **Assessor**)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized\

Learner _____

Date _____

CHECKLIST FOR CLEANING AND DRESSING A WOUND WITH A DRY, STERILE DRESSING	
STEP	SCORE
GETTING READY	
1. Review orders and make sure equipment and supplies are available.	
2. Introduce yourself, identify the patient, explain procedure, and check for latex allergy.	
3. Perform hand hygiene.	
4. Place water-resistant Biohazard bag or container in easily accessible location.	
5. Help the patient to a comfortable position where wound is easily accessible.	
6. Put on clean disposable gloves.	
PROCEDURE	
7. Check for position of drains (if any), remove dressing, look at wound, and record any problems.	
8. Remove gloves by inverting and place in Biohazard bag.	
9. Prepare sterile field and put on sterile gloves.	
10. Clean wound and around any drains, appropriately dry wound area, and place all used gauze wipes in Biohazard bag. (Do not touch anything to contaminate gloves or forceps and clean from center of wound out without retracing.)	
APPLYING A DRY STERILE DRESSING	
11. Apply antimicrobial ointment with gauze wipe, if ordered, and place in Biohazard bag.	
12. Apply two layers of dry, sterile dressing without contaminating gloves or forceps.	
13. Cover wound with surgi-pad, check that all disposable items have been placed in Biohazard bag, and reusable items are folded into sterile field drape.	
14. Remove gloves by inverting and place in Biohazard bag.	
15. Secure dressing with ties or tape as ordered and reposition patient.	
16. Perform hand hygiene.	
17. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO CLEAN AND DRESS A WOUND WITH A DRY, STERILE DRESSING

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 47.2: DRESSING A SIMPLE WOUND⁴

(To be used by the **Assessor** at the end of the module)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

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Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR DRESSING A SIMPLE WOUND	
STEP	SCORE
GETTING READY	
1. Greet the patient respectfully and with kindness.	
2. Explain the procedure to the patient and check for tape and iodine allergies.	
3. Perform hand hygiene. Put on gloves and appropriate PPE.	
4. Prepare the necessary equipment and supplies.	
BANDAGING	
5. Position the patient and expose the area.	
6. Clean the site using iodine or other antiseptic if necessary. Irrigate with saline if necessary.	
7. Apply sterile gauze pads or roll depending on the type of wound to be covered.	
8. Use appropriate tape to hold bandage in place.	
POST-PROCEDURE STEPS	
9. Dispose of waste materials in appropriate container.	
10. Remove PPE.	
11. Perform hand hygiene.	
12. Document procedure and/or findings.	
TOTAL	

⁴ Adapted from: Zambia Clinical Officer Student Learning Guide.

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO DRESS A SIMPLE WOUND

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 47.3: INCISION AND DRAINAGE⁵

(To be used by the **Assessor** at the end of the module)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

LEARNER _____ **Date** _____

CHECKLIST FOR INCISION AND DRAINAGE	
STEP	SCORE
GETTING READY	
1. Greet the patient respectfully and with kindness.	
2. Explain the procedure to the patient and obtain consent.	
3. Perform hand hygiene. Put on gloves and appropriate PPE.	
4. Prepare the necessary equipment using aseptic technique.	
INCISION AND DRAINAGE	
5. Expose the affected part to be incised and drained.	
6. Clean the site using iodine or other antiseptic.	
7. Give local anesthesia, 0.5% lignocaine or bupivacaine.	
8. Drape the affected area.	
9. Incise the abscess or boil using a scalpel and artery forceps. Place a drain if applicable.	
10. Collect a specimen for culture and sensitivity.	
11. Apply sterile dressing.	
12. Remove the drape from the patient.	
POST-PROCEDURE STEPS	
13. Dispose of waste materials in appropriate container. Place sharps including scalpel in sharps container.	
14. Remove PPE.	
15. Perform hand hygiene.	
16. Document procedure and/or findings.	
TOTAL	

⁵ Adapted from: Zambia Clinical Officer Student Learning Guide.

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM INCISION AND DRAINAGE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

CHECKLIST 47.4: IRRIGATING WOUNDS

(To be completed by the **Assessor**)

Place a “1” in score box if STEP is performed satisfactorily or is not applicable OR a “0” if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

Learner _____

Date _____

CHECKLIST FOR IRRIGATING WOUNDS	
STEP	SCORE
GETTING READY	
1. Verify the physician’s order.	
2. Gather materials.	
3. Greet the client.	
4. Explain procedure.	
5. Assist the client to a position in which the irrigation solution will flow by gravity, from the upper end of the wound to the lower end and then into the basin.	
PROCEDURE	
6. Place the waterproof drape over the client and the bed.	
7. Remove the old dressing and clean the wound.	
8. Irrigate the wound with normal saline.	
9. Using the syringe, gently instill a steady stream of irrigating solution into the wound.	
10. Make sure all areas of wound are irrigated.	
11. Continue irrigating until the solution becomes clear.	
12. Using dressing forceps or sterile gloves and sterile gauze, dry the area around the wound.	
13. Assess and dress the wound.	
14. Perform hand hygiene.	
15. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO IRRIGATE WOUNDS

Assessor’s Signature _____ Date _____

Assessor’s Printed Name _____

Comments (in case of need to remediate or other):

47.5: PROCEDURES RELATED TO SURGICAL ASEPSIS

Procedure: Donning Sterile Gloves (Open Method) – See Learning Guide and Checklist

Procedure: Opening Sterile Wrapped Packages

1. Perform hand hygiene for surgical asepsis before assembling equipment.
2. Check sterile package for dryness and date of expiration.
3. Place the package in the center of the work area so that the top flap of the wrapper opens away from you.
4. Reach around the package, NOT over it. Pinch the first flap on the outside of the wrapper between the thumb and index finger. Pull the flap open, laying it on the far surface.
5. Repeat for the side flaps opening the top one first.
6. Pull the fourth flap toward you by grasping the corner that is turned down.
7. Lay the last flap on the near surface, being sure not to touch clothes.
8. Add solutions as necessary for the procedure for which contents are required.

Procedure: Opening Sterile Towel and Other Items

1. Hold items in one hand and use the other hand to open package using same method as above.
2. With the one hand holding the sterile item, the other hand peels back the wrapper and holds the edges back.
3. The sterile item can then be dropped onto the sterile field.

Commercially Prepared Items

1. Locate peel-back edge and peel off paper.
2. The inside of paper package is sterile and can be used as a sterile field, or the objects can be dropped from the paper wrapper onto sterile field.

Procedure: Pouring Sterile Solutions

Steps

1. Perform hand hygiene for surgical asepsis.
2. Remove the lid or cap from the bottle and invert it before placing it on a non-sterile surface.
3. Hold the bottle with the label uppermost.
4. Pour a little liquid over the rim into the waste container.
5. Place the sterile receptacle for the liquid near the edge of the sterile field.
6. Hold the bottle of fluid 4–6 inches above the receptacle and pour the solution. Do NOT reach over the sterile field.
7. Replace lid securely on the container, touching only the outside of it.

*****Note: Lip of flask is not sterile.***

Procedure: Using Sterile Forceps
Types of

1. Curved forceps
2. Hemostat: straight forceps
3. Sponge forceps, also known as "pickups": rounded spatula-like tips
4. Tissue forceps: like tweezers, supplied with or without teeth

Purpose: Transferring of sterile items, packing gauze into small area that hand cannot enter, used to hold towels and drapes in place, used to hold needles and catheters in place.

CHECKLIST 47.6: STERILE DRESSING CHANGE

(To be used by the Assessor)

Place a "1" in score box if STEP is performed satisfactorily or is not applicable OR a "0" if it is not performed satisfactorily or if not observed. *Checklists may be used in simulation or in the clinical area and should be used for practice prior to assessment.*

No step should be left blank.

Satisfactory= 1: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory= 0: Does not perform the step or task according to the standard procedure or guidelines

Not applicable= 1: The step does not apply in the setting, for example, if certain resources are not available in the clinic versus hospital or gloves/supplies are disposed of versus sterilized

LEARNER _____ **Date** _____

CHECKLIST FOR STERILE DRESSING CHANGE	
STEP	SCORE
GETTING READY	
1. Prepare the necessary equipment.	
2. Tell the woman (and her support person) what is going to be done, listen to her attentively, and respond to her questions and concerns.	
3. Provide continual emotional support and reassurance, as possible.	
CHANGING THE DRESSING	
4. Position and drape patient for privacy.	
5. Perform hand hygiene.	
6. Open waxed paper or plastic bag and attach to over-bed table.	
7. Cut strips of tape and place on edge of table.	
8. Open sterile water or saline solution and open sterile container. Pour solution into sterile container.	
9. Peel open cotton-tipped applicator package at wooden stick end. Touching only that end, place into solution.	
10. Put on single-use, clean examination exam gloves.	
11. Remove tape from old dressing.	
12. Remove dressing one layer at a time. Change gloves if visibly soiled.	
13. Inspect wound and dressing for amount, color, odor of drainage, and signs of infection: erythema, swelling.	
14. Clean skin edges and wound with moistened sterile applicator if visibly soiled or as directed.	
15. Discard soiled dressing, applicators, and gloves.	
16. Set up sterile field: sterile towel or sterile glove packet. Drop needed 4 X 4s on sterile field.	
17. Put on sterile gloves.	
18. Place sterile 4 X 4s over incision.	
19. Cover entire dressing with ABD pad, placing side that was up towards the wound.	
20. Remove gloves. Tape dressing across the top, middle, and bottom.	
21. Record date and time of dressing change and wound observations.	
22. Notify nurse in charge or doctor if signs of new or worsening infection.	

CHECKLIST FOR STERILE DRESSING CHANGE	
23. Perform hand hygiene.	
24. Document procedure and/or findings.	
TOTAL	

Learner IS ☐ **QUALIFIED** ☐ **NOT QUALIFIED** TO PERFORM STERILE DRESSING CHANGE

Assessor's Signature _____ Date _____

Assessor's Printed Name _____

Comments *(in case of need to remediate or other)*:

STERILE DRESSING CHANGE PROCEDURE

Equipment:

1 or 2 pairs of non-sterile exam gloves
1 pair of sterile gloves
Sterile normal saline

Sterile cotton-tipped applicators

Small sterile container for solutions

4 X 3 gauze pads

Tape

Waxed or plastic bag

Procedure:

1. Gather equipment.
2. Wash your hands.
3. Explain procedure to patient, if appropriate.
4. Position and drape patient and provide for privacy.
5. Open waxed paper or plastic bag and attach to over-bed table.
6. Cut necessary strips of tape and place them on edge of table.
7. Open sterile container and pour solutions into container.
8. Peel open cotton-tipped applicator package at wooden stick end. Touching only that end, place into solution.
9. Put on non-sterile gloves.
10. Remove tape by pulling tape towards wound.
11. Remove dressing one layer at a time. Change gloves if visibly soiled.
12. Observe wound and dressing for amount, color, odor of drainage, and signs of infection.
13. Using one applicator at a time, clean incision with downward strokes. Turn applicator while pulling down. Use all surfaces of applicator once. Change applicator after all surfaces used. Clean incision, the right of incision, and then left of incision, each time with new applicator(s).
14. Discard dressing and gloves in bag.
15. Set up sterile field:
 - a. Sterile towel or sterile glove packet
 - b. Drop needed 4 X 4s on sterile field. Gauze should not touch the 1-inch border of the sterile field.
16. Put on sterile gloves.
17. Place 4 X 4s over incision.
18. Cover entire dressing with ABD pad, placing side that was up toward the wound.

19. Remove gloves. Tape dressing across the top, middle, and bottom. Date and time dressing.
20. Dispose of old dressing by securing bag opening and placing in red plastic bag.
21. Perform hand hygiene.
22. Document procedure and/or findings.

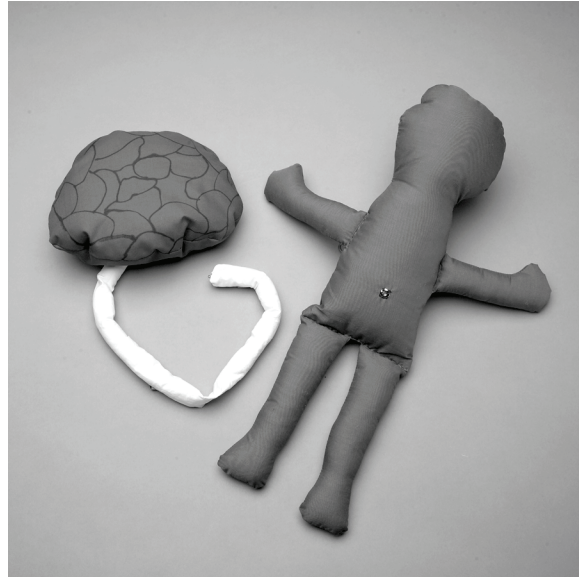
APPENDIX: SAMPLE INSTRUCTIONS FOR LOCALLY MADE MODELS FOR CORE MANAGEMENT TEAM OF SIMULATION LABS.

INSTRUCTIONS FOR MAKING CLOTH MODELS⁶

BABY, PLACENTA AND CORD

Materials Needed: Baby

1/3 yard light brown material (medium weight cotton or cotton/polyester)
Light brown sewing thread
Baby pattern
Polyester or polyester/cotton stuffing material (stuffing from a bed pillow works well)
Sewing needle or sewing machine
Sewing scissors
Dark brown or black permanent fine tip marker
Large metal snap (female side)
Straight pins



Materials Needed: Placenta and Cord

¼ yard red material (medium weight cotton or cotton/polyester or polyester)
¼ yard white material (medium weight cotton or cotton/polyester)
Placenta and cord pattern
Red sewing thread
White sewing thread
Sewing needle or sewing machine
Black permanent marker
Polyester or polyester/cotton stuffing material (stuffing from a bed pillow works well)
Large metal snap (male side)
Sewing scissors
Straight pins
Tweezers or artery forceps

Instructions for Baby

Place pattern on a double layer of light brown material (body, leg, and arm). Pin the pattern in place. Cut around pattern with a sharp sewing scissors. Unpin the pattern.

Place the arm and leg pattern again on the double layer of material (to make a second arm and leg). Pin the pattern into place, cut, and unpin. Place the two pieces of the body with the right sides together. Pin into place. Place marks where the arms will be inserted (see marks on the pattern). Stitch ½" (1.2 cm) from edge of material leaving open between the marks where the arms will be inserted and leaving open the bottom of the body where the legs will be inserted. Turn the body right side out and stuff.

⁶ Patterns designed and developed by Annie Clark, CNM, American College of Nurse-Midwives. To make any of these models, double the size of the patterns given in this appendix. If a photocopier is available, enlarge the pattern by 200%.

Place the two pieces of one leg with the right sides together. Pin into place. Stitch $\frac{1}{2}$ " (1.2 cm) from edge of material leaving the top of the leg open. Remove pins. Turn right side out. Stuff the leg. Repeat with the other leg.

Place the two pieces of one arm with the right sides together. Pin into place. Stitch $\frac{1}{2}$ " (1.2 cm) from the edge of material leaving the top of the arm open. Remove pins. Turn right side out. Stuff the arm.

Take one arm and ease into the body (make sure the baby's thumb is up). Turn the raw edges under. Pin in place. Top stitch the arm into place. Remove pins. Repeat with the other arm.

Take one leg and ease into the body. Turn the raw edges under. Pin in place. Take the other leg and ease into the body. Turn the raw edges under. Pin in place. Put additional stuffing into body, if needed. Pin the crotch closed. Top stitch legs into place and top stitch crotch closed.

Sew the female end of the snap in the middle of the body where the bellybutton would be.

Instructions for Placenta and Cord

Place placenta pattern on a double layer of the red material. Pin the pattern in place. Cut around pattern with a sharp sewing scissors. Unpin the pattern. Place the two right sides of the fabric together. Pin together about 1" (2.5 cm) from the edge. Sew the two pieces of material together $\frac{1}{2}$ " (1.2 cm) from the edge of the material. Leave a 2" (5 cm) space unsewn. Remove the pins. Turn the "placenta" right side out. Stuff with the stuffing material until about 1" (2.5 cm) thick. Turn the edges of the open 2" (5 cm) seam and stitch closed.

Fold over the white material. Place cord pattern with edge indicated on fold of white material. Pin pattern into place. Cut along the edge of the pattern. Unpin the pattern from the material. Fold the material so the two right sides of the fabric face each other. Pin 1 inch (2.5 cm) from the edge. Sew $\frac{1}{2}$ " (1 cm) from the edge of the material. Remove the pins. Turn the cord right side out. (Use the tweezers or artery forceps to help pull the material right side out.) Loosely stuff the cord using the tweezers or artery forceps. (Do not overstuff. The cord should be squeezable, not hard like a rope). Turn the raw edges at each end of the cord inward. Stitch one end of the cord closed. Sew the male side of the snap to this end of the cord. Sew the other end of the cord to the middle of the placenta.

On the fetal side of the placenta (the side the cord is sewn onto), draw arteries and veins using the permanent marker.

On the maternal side of the placenta, draw cotyledons.

UTERUS

Materials Needed: Uterus

¼ yard pink material (medium weight cotton or cotton/polyester)
26" (66 cm) white shoelace or ¼ " (0.5 cm) wide pink or white ribbon
Pink sewing thread
Small safety pin (if using ribbon instead of shoelace)
Straight pins
Uterus pattern
Polyester or polyester/cotton stuffing material (stuffing from a bed pillow works well)
Sewing scissors
Sewing needle or sewing machine



Instructions

Place placenta pattern on a double layer of the pink material. Pin the pattern in place. Cut around pattern with a sharp sewing scissors. Unpin the pattern. Hold one piece of material so the wrong side of the material is facing you. Fold under ¼" (0.5 cm) of the straight edge (cervix) of the piece, and pin to hold. Stitch by hand or machine. Remove pins. Repeat with the other piece. Now place the two pieces of material with the right sides together. Pin to hold. Stitch ½" (1.2 cm) from the edge all the way around the uterus, but leave the straight edge (cervix) unstitched. Unpin. Now fold the straight edge under again 5/8" (1.5 cm), creating a casing, and pin to hold. Stitch ½ " (1.2 cm) from the folded edge leaving ½ " (1.2 cm) unstitched. Insert the end of the shoelace through the opening and work it through and out the other end of the casing. Hold the end of the shoelace and slide the material along the shoelace until equal amounts of the shoelace are exposed from each side of the casing. (If using ribbon, attach a small safety pin to the end of the ribbon and work it through the casing in the same manner.) Turn the uterus right side out. Stuff the uterus until about 2" (5 cm) thick. Tie shoelaces or ribbon in a bow to secure.

PELVIS

Materials Needed

$\frac{3}{4}$ yard white or beige material (medium weight cotton or cotton polyester)

Pelvis pattern

White or beige sewing thread

Beige embroidery thread-1 skein

Heavy 3" (8 cm) sewing needle with large eye

Polyester or polyester/cotton stuffing material (stuffing from a bed pillow works well)

Aluminum soft drink can

Sewing needle or sewing machine

Straight pins

Sewing scissors

Pencil



Instructions

Place pelvis pattern on a double layer of white or beige material. Pin the pattern in place. Cut around pattern with a sharp sewing scissors. Unpin the pattern. Take the two pieces you have cut out and put them together so the right sides of the material are facing each other. Pin into place. Stitch $\frac{1}{2}$ " (1.2 cm) from edge of material leaving open between the marks at the spine where the stuffing will be inserted. Turn the pelvis right side out. On both sides of the pelvis, mark the pelvis with a pencil where the embroidery stitches will be placed according to the pattern. Cut a piece of aluminum from the pattern for the tailbone with the scissors. Slide the piece of aluminum inside the pelvis where the tailbone will be. Stuff the entire pelvis firmly with stuffing. Bring the two edges of the pubic bone together and stitch both front and back of pubic bone.

Finishing-Thread the heavy needle with the embroidery thread. Stitch along the iliac crest as indicated on the pattern. Use stitches $\frac{1}{2}$ " (1.2 cm) long and stitch from the front of the iliac crest to the back and then stitch forward again so your stitches fill in and make a solid line of stitching.

Repeat with the other iliac crest.

Use the heavy needle with embroidery thread. Knot the end of the thread. Insert the needle through one of the pencil marks on the inside of the pelvis and come through the opposite mark on the outside of the pelvis. Pull tight. Insert the needle through the same mark on the outside of the pelvis to the inside of the pelvis. Repeat one more time inserting the needle through the same mark on the inside of the pelvis to the outside of the pelvis. Pull tight and secure with a knot. Cut the thread free being careful not to cut off the knot. Repeat this process for all of the pencil marks. When stitching the tailbone, insert needle through both the material and the aluminum piece inside.

Fold over the raw edges of the spine where the stuffing was inserted, pin together, and stitch closed. Remove pins.

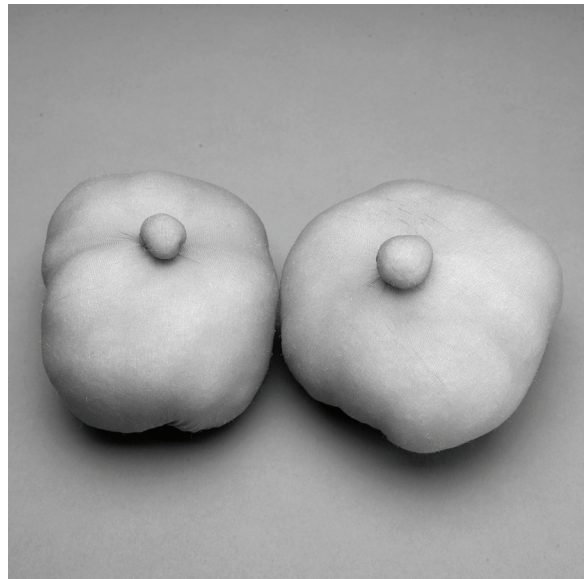
INSTRUCTIONS FOR MAKING A BREAST MODEL

Materials Needed for One Model

Sewing needle
Sewing thread (color does not matter)
(2) Lower legs or upper legs of brown panty hose
2 large handfuls of polyester or polyester/cotton stuffing from a pillow
2 small plain rubber bands (not colored)
Black marker with permanent ink
Piece of white cotton cloth 152 cm long and 10 cm wide (a piece of sheet works well)

Instructions

- Cut the panty and the toes off of a pair of pantyhose. Cut the two pieces from the legs in half so you have 4 tubes. (You will need 2 tubes).
- Take a handful of stuffing and push it into the center of one of the pantyhose tubes. Repeat with a second tube. These will become the breasts.
- Fold the excess of the pantyhose material so that it overlaps behind the “breast.” Take a few stitches with a needle and thread to hold the flaps down. Repeat with the second “breast.”
- Pinch the front of the “breast” to form a nipple and bind with a small rubber band. Repeat with the second “breast.”
- Take the piece of sheet and tie it around your chest. Make a mark on the cloth where you feel your own nipples beneath the cloth.
- Remove the piece of sheet and sew the “breasts” on over each mark you made.
- Color the nipple and make an areola with the black marker on each “breast.”
- Tie the model on around your chest for teaching breastfeeding, breast exam, pregnancy, childbirth, or postpartum role plays.



INSTRUCTIONS FOR MAKING INFANT “BEANIES”

Materials Needed for One Beanie

A size D or 3 crochet hook
Baby or fingering weight yarn

Crocheting Pattern

Ribbing: Chain (ch) 8 stitches (sts); turn, single crochet (sc) into 2nd ch from hook and each st across. Ch 1, turn. Row 2: Sc into back loop only of each sc across. Ch 1, turn. Repeat (rep) row 2 until there are 24 ridges. Fasten off and sew seam in ribbing to form a circle.

Attach yarn at seam and ch 3. Double crochet (dc) in end of each row of ribbing; slip stitch (sl st) to join, ch 3. Work 4 rounds (rnds) of dc joining rnds with sl st.

1st decrease (dec) Rnd: Ch3 * dc 3, dec on next 2 sts; rep from * around, ending dc on any extra sts. Work 1 rnd even.

2nd Dec Rnd: Ch 3 * dc 2, dec on next 2 sts; rep from * around, ending dc any extra sts. Work 1 rnd even.

3rd Dec Rnd: Ch 3 * dc 1, dec on next 2 sts, rep from 1 ending dc any extra sts. Work 1 rnd even.

4th Dec Rnd: Ch 3 * dec on next 2 sts; rep from * around, ending dc any extra sts. Draw together remaining sts and fasten off securely.

Knitting Pattern

Use #4 needles and baby weight yarn.

Cast on 72 stitches (sts).

Knit (k) 2, Purl (p) 2 or 3 inches.

K the next 2 rows to make a ridge on the right side.

P one row.

Work in Stockinette Stitch (st st; k one row, p one row) for 14 rows.

K the next 2 rows to make another ridge.

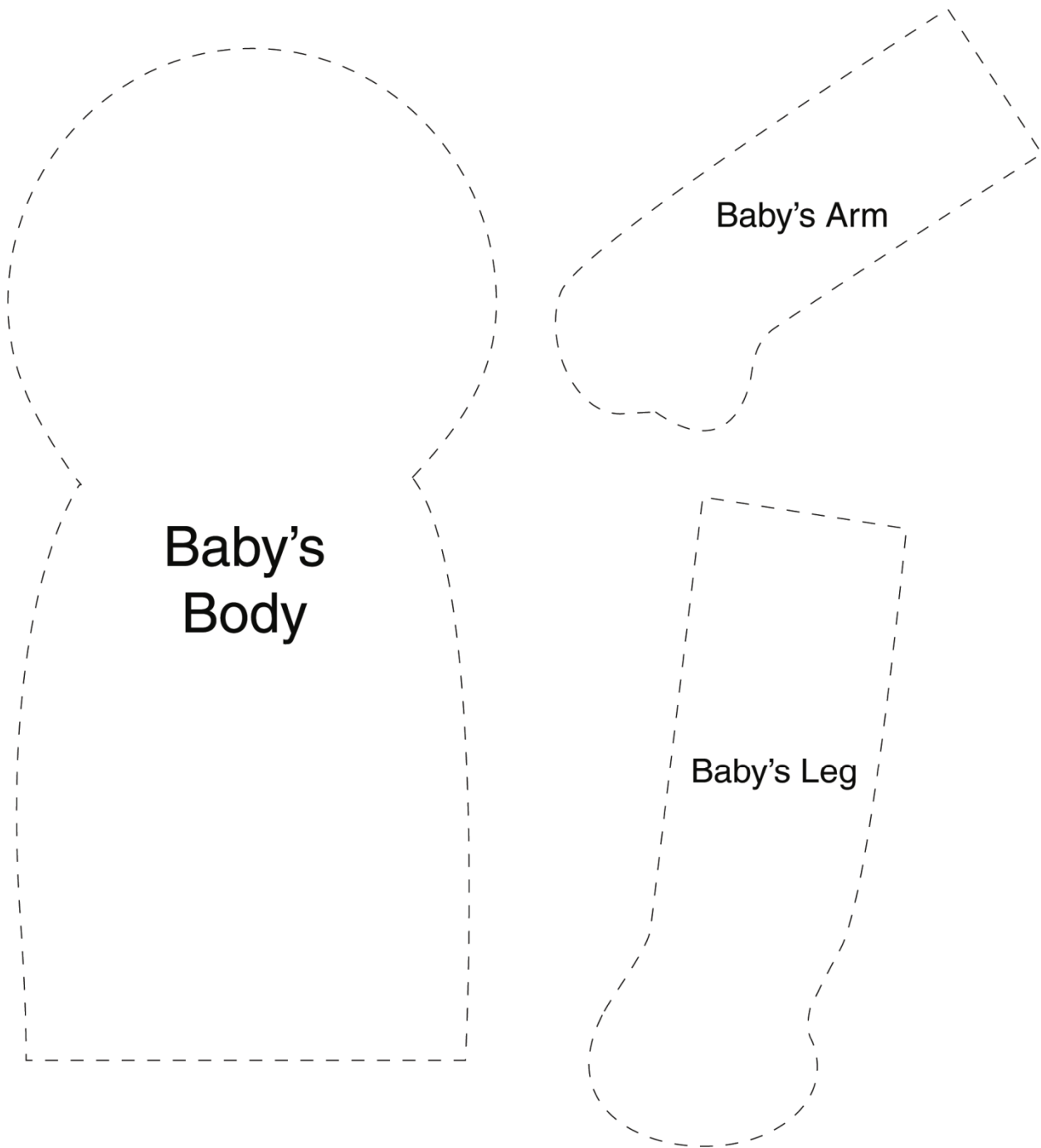
P one row. Next row: k2 together (tog) across row.

Repeat the last two rows until you have 9 sts remaining on the needle.

Leave a strand of yarn long enough to weave the back seam together, draw the strand through the 9 sts and fasten.

Weave the back seam together.

PATTERNS⁷



⁷ To make any of these models, double the size of the pattern. If a photocopier is available, enlarge the pattern by 200%.

